

MARGIN RESERVED FOR BINDING
WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County MontgomeryVillage or City Cherry Chase (No. 4)2 FULL NAME Clement Rene DagneauxSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216St. E. Irving Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)6 DATE OF BIRTH April 11, 1876
(Month) (Day) (Year)7 AGE 54 yrs. 5 mos. 27 ds. or LESS than 1 day hrs. min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Caterer
(b) General nature of industry, business, or establishment in which employed or (employer) 9 BIRTHPLACE (State or country) France10 NAME OF FATHER Francois Dagneaux11 BIRTHPLACE OF FATHER (State or country) France12 MAIDEN NAME OF MOTHER Marie Clementine Payet13 BIRTHPLACE OF MOTHER (State or country) France

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Augustine Dagneaux(Address) 4 East Irving St. E. C. C.15 Filed 10-9-1930 Thomas Kloned
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 8, 1930
(Month) 8 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 1927 to October 8, 1930
that I last saw him alive on October 8, 1930and that death occurred on the date stated above, at 1:15 a.m.
The CAUSE OF DEATH* was as follows:Chronic Nephritis, Arterio-
Sclerosis, Chronic Cardiac
Dilatation, Mitral Insufficiency,
(Duration) 3 yrs. 6 mos. ds.Contributory apoplexy
Secondary (Duration) 1 yrs. 1 mos. 1 ds.(Signed) Franklin Nelson M. D.
Oct 8, 1930 (Address) The Sherman Wash DC

*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients & Recent Residents)

At place of death 14 yrs. mos. ds. In the State 14 yrs. mos. ds.Where was disease contracted, if not at place of death? Former Washington DC
usual residence19 PLACE OF BURIAL OR REMOVAL Washington DC DATE OF BURIAL Oct 10, 193020 UNDERTAKER G. J. Thrift ADDRESS 1414 G St. SE Wash DC

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930

BUREAU

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1 PLACE OF DEATH

County

Montgomery

15135

(188-C)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

217

Village or City

Elney

(No.)

Montgomery Co. San Hrofo

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Clara Daniels

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

N.

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7 AGE

18

yrs.

mos.

ds.

If LESS than

1 day hrs.

or min.

8. OCCUPATION

(a) Trade, profession or particular kind of work

Hb

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

H. C.

10 NAME OF FATHER

Morris Howard

11 BIRTHPLACE

OF FATHER

(State or country)

Barcroft, Va

12 MAIDEN NAME

OF MOTHER

Laura V. Rice

13 BIRTHPLACE

OF MOTHER

(State or country)

Baileys Cross Rd. Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Rice

(Address)

Glencarlyn, Va

15

Filed

Dec 6

1928

Mrs. C. S. Bunsley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

12/6/30

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

12/6/

1930

to

12/6/

1930

that I last saw her alive on 12/6/1930

and that death occurred on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH * was as follows:

Punctures from 3 vagin. & external
due to automobile accident. Colles-
rice pike. Montgo

(Duration)

yrs.

mos.

ds.

Contributory
Secondary

H. Montgo

(Duration)

yrs.

mos.

ds.

(Signed)

12-6-

1930

(Address)

Sandy Spring

M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

30 minutes

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clarendon, Va

12-9-30

20 UNDERTAKER

ADDRESS

C. J. Jones

Clarendon, Va

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Artificer, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data are essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 3 1931

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City in Laytonsville (No. _____) St. _____ Ward _____

2 FULL NAME Baby Darby

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) None

6 DATE OF BIRTH August 12 12, 1930
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 1 LESS than 1 day _____ hrs. _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer) None

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Joseph C. Darby

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ethel C. Green

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Helen Green

(Address) Faithersburg

15 Filed Aug 3 1930 V. H. Dixon Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8/12, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 8/12 1930 to 8/12 1930.

that I last saw him alive on 8/12 1930.

and that death occurred on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH * was as follows:

Still Born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Chas. L. Smith M. D.

8/12 1930 (Address) Laytonsville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Faithersburg Cemetery August 13, 1930

20 UNDERTAKER ADDRESS

Roy W. Barby Faithersburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 6 1930

BUREAU

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1 PLACE OF DEATH

County Montgomery

10531

(73)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213Village or City Rockville (No. Chestnut Lodge Sanitarium Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Alexander H Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)6 DATE OF BIRTH June 15, 1857
(Month) (Day) (Year)7 AGE 73 yrs. 2 mos. 24 ds. or min.?
If LESS than 1 day... hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Chief Steward - Hotel
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE
(State or country) Virginia10 NAME OF FATHER Henry W Davis11 BIRTHPLACE OF FATHER
(State or country) Virginia12 MAIDEN NAME OF MOTHER Alice Priest13 BIRTHPLACE OF MOTHER
(State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry W Davis- (Address) 3900 Kansas Ave. N.W.15 Filed Sept. 8, 1930 by Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 8, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 23, 1930 to Sept 8, 1930
that I last saw him alive on Sept 8, 1930and that death occurred on the date stated above, at 6:45 P.

The CAUSE OF DEATH was as follows:

Pseudo Bulbar Paralysis(Duration) 2 yrs. mos. ds.Contributory
Secondary(Duration) yrs. mos. ds.(Signed) Arthur M. Bullard M. D.
Sept 8, 1930 (Address) Rockville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 16 ds. In the State 1 yrs. 1 mos. 16 ds.Where was disease contracted, if not at place of death? unknownFormer or usual residence Washington, D.C.19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL Sept. 8, 193020 UNDERTAKER W. W. Chambers ADDRESS Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrovascular fever* (the only definite synonym is "Epidemic cerebrovascular meningitis"); *Diphtheria* (avoid use of "Croup," "Typhoid fever (never report "Typhoid Pneumonia," "Lobar pneumonia, Broncho pneumonia ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Chorionoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 4 1930

BUREAU

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¹ PLACE OF DEATH
County MTg

Village or City Liberty Spring (No. _____)

² FULL NAME Mrs Lydia A. Davis

03093 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Oct. 22, 1855
(Month) (Day) (Year)

7 AGE 84 yrs. 5 mos. 20 ds. If LESS than 1 day ____ hrs. ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Home wife
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) MTg Co.

10 NAME OF FATHER Lloyd Green

11 BIRTHPLACE OF FATHER (State or country) MTg Co.

12 MAIDEN NAME OF MOTHER Hannah Fawcett

13 BIRTHPLACE OF MOTHER (State or Country) England.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary Biggs
(Address) Liberty Spring, Md.

15 Filed Mar 13 1930 J. E. Wenden
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 12, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 2, 1930 to March 12, 1930, that I last saw her alive on March 12, 1930 and that death occurred on the date stated above, at 4:30 p.m. The CAUSE OF DEATH * was as follows:

Ruptured cerebral vessel

(Duration) ____ yrs. ____ mos. 10 ds.
Contributory Myocardial
Secondary and atherosclerosis
(Duration) 2 yrs. 0 mos. 0 ds.

(Signed) W. B. H. Agnew M.D.
March 13, 1930 (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville Union DATE OF BURIAL Mar 14, 1930

20 UNDERTAKER W. B. Humphrey ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At Home, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. hausion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leuæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 7 1930
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Travilah (No. _____)

2 FULL NAME Mary Catharine Harris

04445

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH March 24, 1930
(Month) (Day) (Year)

7 AGE 0 yrs. 1 mos. 2 ds. or LESS than 1 day _____ hrs. _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Henson Harris

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Maggie Martin

13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henson Harris
(Address) Spithurst # 3

15 Filed 4-26 1930 Mrs. J. R. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 26, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 20 apr 1930 to 26 apr, 1930

that I last saw him alive on 20 apr, 1930

and that death occurred on the date stated above, at 4 A m.

The CAUSE OF DEATH * was as follows:

dis. colitis

(Duration) _____ yrs. _____ mos. 8 ds.

Contributory
Secondary

(Signed) Douglas W. Barber M. D.
26 apr 1930 (Address) Spithurst # 3

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 1 mos. 2 ds. In the State 0 yrs. 1 mos. 2 ds.

Where was disease contracted, if not at place of death? same

Former or usual residence same

19 PLACE OF BURIAL OR REMOVAL Travilah, Ind DATE OF BURIAL April 27 1930

20 UNDERTAKER E. C. Martner ADDRESS Spithurst

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 5 1920

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH *Montgomery*
County *Prince George*

(129)

15136

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *214*Village or City *Silver Spring* (No. *_____*)*Ridge*St. *_____* Ward *_____* (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME *Susan R. Davis*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*
(Write the word)

6 DATE OF BIRTH *unknown*
(Month) (Day) (Year)

7 AGE *88* yrs. *_____* mos. *_____* ds. or *_____* min. If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Maryland*

10 NAME OF FATHER *unknown*

11 BIRTHPLACE OF FATHER (State or country) *unknown*

12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (State or country) *unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry S. Davis(Address) *642-380 St. ne*

15 Filed *Dec 3 1930* *J. S. Wadsworth*
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Dec. 3 1930*
December (Month) *3* (Day) *1930* (Year)

17 I HEREBY CERTIFY, That I attended the deceased from *March 15 1928* to *Dec. 3 1930*

that I last saw her alive on *November 27 1930*

and that death occurred on the date stated above, at *4:20 a.m.*

The CAUSE OF DEATH * was as follows:

general arterio-sclerosis
arterial hypertension
chronic interstitial nephritis

(Duration) *2* yrs. *8* mos. *_____* ds.Contributory
Secondary*Anaemia*

(Signed) *John P. Simpson* M. D.
Dec. 3 1930 (Address) *181 Laurel St. ne*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington D.C. *Dec. 4, 1930*
20 UNDER TAKEN BY *S. E. Davis* ADDRESS *1432 Jan St.*
1928. 14th St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer. Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scranal, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the **EAST CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death, 29 ds.; Bronchopneumonia (secondary, 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory."* (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931

BURK

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Kenton Station

STATE OF MARYLAND
CERTIFICATE OF DEATH

04446

(57)

Registration Dist. No.

213

2 FULL NAME

Ursula M. Davis

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWER,

OR DIVORCED

(Write the word)

Widow

6 DATE OF BIRTH

March

6

1869

(Month)

(Day)

(Year)

7 AGE

61

1

7

If LESS than

1 day.... hrs.

.....yrs.....mos.....ds. or.....min. ?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Rhode Island

10 NAME OF FATHER

Robert Smith

11 BIRTHPLACE OF FATHER

(State or country)

England

12 MAIDEN NAME OF MOTHER

Anna Smith

13 BIRTHPLACE OF MOTHER

(State or country)

Canada

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norman Davis

(Address)

Kenton Station, Md.

15

Filed

4-14

1923

Mrs. H. T. Pratt

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April

13

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

April 9

1930

to April 13

1930

that I last saw him alive on April 12

1930

and that death occurred on the date stated above, at 11:55 P. M.

The CAUSE OF DEATH was as follows:

Diabetes

(Duration) 2 yrs. mos. da.

Contributory Secondary

Arterio Sclerosis

(Duration) 2 yrs. mos. da.

(Signed)

Eugene Snowden

M. D.

April 14

1930

(Address)

1712

21st

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal Washington D.C.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs.

mos.

da.

In the State

yrs.

mos.

da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington, D.C.

April 14, 1930

20 UNDERTAKER

ADDRESS

W. B. Rankin Co.

1400 Chapin Washington D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Printer*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeeper* who receive a definite salary), may be entered as, *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Neurotrophal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is to be used over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 8 1930
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day 8 hrs.
or 0 min.?

8 OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER

(State or country)

12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

June 3 1930

William E. Lewis
Local Registrar

07170

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 211

St. Ward

(If death occurred in
a hospital or institution,
give its NAME instead of
street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

6/3/30(?) 192
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at 7 m.

The CAUSE OF DEATH was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

6/3/30

(Address)

State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-
ients or Recent Residents)At place
of death 0 yrs. 0 mos. 0 ds.In the
State 0 yrs. 0 mos. 0 ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rocky Hill, Md.

6/4/30

20 UNDERTAKER

ADDRESS

Marshall N. Day

Clarkburg, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Brochopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montg.</u>		01800 (44)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Carlsburg</u> (No. _____)		St. _____ Ward _____		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>George E. Day</u>					
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>married</u>	16 DATE OF DEATH <u>2-23-1930</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>May-25-1854</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>1-8-1930</u> to <u>2-23-1930</u> that I last saw him alive on <u>2-21-1930</u> and that death occurred on the date stated above, at <u>2:30 A.</u> m. The CAUSE OF DEATH * was as follows: <u>Carcinoma of Stomach</u>		
7 AGE <u>75</u> yrs. <u>8</u> mos. <u>28</u> ds. or min.?			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____		
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer) <u>retired farmer</u>			Contributory Secondary <u>Sanitary</u> (Signed) <u>M. C. Vint</u> M. D. <u>2-28-1930</u> (Address) <u>Garthensburg Md.</u>		
9 BIRTHPLACE (State or country) <u>Md.</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
10 NAME OF FATHER <u>Thomas Day</u>			15 PLACED FOR BURIAL OR REMOVAL <u>Md.</u> DATE OF BURIAL <u>Feb 25-1930</u>		
11 BIRTHPLACE OF FATHER <u>Maryland</u>			20 UNDERTAKER <u>G. B. Garthensburg</u>		
12 MAIDEN NAME OF MOTHER <u>Leah Wolfe</u>			ADDRESS <u>Garthensburg Md.</u>		
13 BIRTHPLACE OF MOTHER <u>Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sniah Day</u> (Address) <u>Bayd, Md. Md.</u>					
15 Filed <u>Feb 24 1930</u> <u>W. E. Lewis</u> Registrar					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, PUERPERAL peritonitis, etc.*" State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 4 1930
BUREAU U. S.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Montgomery

Village or City Lakeland Park (No. Washington Sanitarium Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Millie De Castro

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH July 18 1870
(Month) (Day) (Year)

7 AGE 59 yrs. 9 mos. 2 ds. or min. If LESS than 1 day... hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer) own home

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Morion Henderson

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary C. Gibson

13 BIRTHPLACE OF MOTHER (State or country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington San. Hosp.

(Address) Penn.

15 Filed April 20 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 20 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr. 15 1930 to Apr 20 1930, that I last saw her alive on Apr 19 1930 and that death occurred on the date stated above, at 4 A.m.

The CAUSE OF DEATH * was as follows:

Angina Pectoris
(Coronary Sclerosis)

(Duration) 2 yrs. mos. ds.

Contributory Secondary Chronic Rheumatoid arthritis

(Duration) 3 yrs. mos. ds.

(Signed) M. D. Apr 20 1930 Address Lakeland Park W.D.

*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs. 4 ds. In the State... yrs. 4 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence North East - Pa.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Eric Penn April 20 1930

20 UNDERTAKER ADDRESS

W. W. Chambers 1400 Chapin St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

MAY 8 1930

BUREAU V. O.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Montgomery

Village or City Cherry Chase (No. 4)

2 FULL NAME William H DeLoay

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE W.H. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married.
(Write the word)

6 DATE OF BIRTH Feb. 8th, 1863
(Month) (Day) (Year)

7 AGE 67 yrs. 23 ds. or min.?
If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Lawyer
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Wash. D.C.

10 NAME OF FATHER Richard DeLoay

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann O'Brien

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William C DeLoay

(Address) 4 W. Kirk, Cherry Chase, Md.

15 Filed Mar 5 1930 Thomas K. Conrad
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3 - 3 - 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 13 1930, 192...

that I last saw him alive on Mar 13 192...

and that death occurred on the date stated above, at ... m.

The CAUSE OF DEATH * was as follows:

acute intermittent indigestion (Patient complained all day march 2nd of gas on stomach)
(Duration) yrs. mos. ds.

Contributory Secondary myocarditis
(Duration) yrs. mos. ds.

(Signed) Thomas K. Conrad M. D.

3 - 3 - 1930 (Address) Cherry Chase, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 15 yrs. mos. ds. In the State ... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wash. D.C. Mar 5, 1930

20 UNDERTAKER ADDRESS

McIntaruth 436-7 SW

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 8 1930

BUREAU

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1 PLACE OF DEATH <i>Maryland</i>			06823			STATE OF MARYLAND CERTIFICATE OF DEATH		
County <i>Rockdale</i>			(101-a)			Registration Dist. No. <i>217</i>		
Village or City <i>Margaret De Mar</i> (No. _____)			St. _____			Ward _____ (If death occurred in a hospital or institution, give its NAME, its stand of street and number.)		
2 FULL NAME <i>Margaret De Mar</i>								
PERSONAL AND STATISTICAL PARTICULARS					MEDICAL CERTIFICATE OF DEATH			
3 SEX <i>F</i>	4 COLOR OR RACE <i>Black</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Married</i>			6 DATE OF DEATH <i>June 17</i> , 19 <i>30</i>			
					(Month) _____ (Day) _____ (Year) _____			
6 DATE OF BIRTH <i>July 17</i> , 19 <i>10</i>					17 I HEREBY CERTIFY, That I attended the deceased from <i>June 7</i> , 19 <i>30</i> to <i>June 11</i> , 19 <i>30</i>			
					(Month) _____ (Day) _____ (Year) _____			
7 AGE <i>20</i> yrs. <i>4</i> mos. _____ ds. or _____ min.?					that I last saw him alive on _____, 19 <i>30</i> , and that death occurred on the date stated above, at _____ m.			
					The CAUSE OF DEATH was as follows: <i>Lobar Pneumonia</i>			
8 OCCUPATION (a) Trade, profession or particular kind of work <i>Lawyer</i> (b) General nature of industry, business, or establishment in which employed or (employer) _____					(Duration) _____ yrs. _____ mos. _____ ds.			
9 BIRTHPLACE (State or country) <i>MD</i>					Contributory Secondary <i>Lobar Pneumonia</i>			
					(Duration) _____ yrs. _____ mos. _____ ds.			
10 NAME OF FATHER <i>Anderson</i>					(Signed) <i>Dr. J. H. ...</i> M. D.			
11 BIRTHPLACE OF FATHER (State or country) <i>MD</i>					<i>June 17</i> , 19 <i>30</i> (Address) <i>...</i>			
12 MAIDEN NAME OF MOTHER <i>Catherine Pigg</i>					*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
13 BIRTHPLACE OF MOTHER (State or Country) <i>MD</i>					16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)			
					At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>J. H. Capeland</i> (Address) <i>...</i>					Where was disease contracted, if not at place of death? Former or usual residence _____			
15 Filed <i>June 14</i> , 19 <i>30</i> <i>C. S. Barnsley</i> Registrar					19 PLACE OF BURIAL OR REMOVAL <i>Lay Moore</i> DATE OF BURIAL <i>June 13</i> , 19 <i>30</i>			
					20 UNDERTAKER <i>Ray Parker</i> ADDRESS <i>Lay Moore</i>			

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

for issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*;

(a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by moving train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE FULLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY as it should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Dec. 24, 1930

as Mrs. C. C. Hillson

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Contributory
Secondary

(Signed)

* Since the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State, yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mountain ME. Cem.

Dec. 26, 1930

20 UNDERTAKER

ADDRESS

Mrs. Hillson & Sons Barnesville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Coal engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Jewelry*; (a) *Barman*, (b) *Automobile factory*. The material selected on both forms part of the second statement. Never return "Laborer," "Foreman," "Manager," "Watchman," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home who are regarded in the duties of the household only (but paid *housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin). "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Fracura," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*, *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *delirium*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered to detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 5 1931

BUREAU

MARGIN RESERVED FOR BINDING
WRITE AGAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County MontgomeryVillage or City Silver Spring (No. 8404 Woodside Parkway St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME Sarah Ellen DeShazo15138 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed6 DATE OF BIRTH May 27, 1868
(Month) (Day) (Year)7 AGE 62 yrs. 6 mos. 26 ds. or _____ min. If LESS than 1 day _____ hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed or (employer) Housewife9 BIRTHPLACE (State or country) Washington, D.C.10 NAME OF FATHER John Hearst11 BIRTHPLACE OF FATHER (State or country) Virginia12 MAIDEN NAME OF MOTHER Ellen Hearst13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. E. DeShazo
(Address) 1430 Belmont St. N.W.15 Filed Dec 23, 1920 J. E. Wadley
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH DEC 23, 1920
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov. 11, 1920 to DEC 23, 1920, that I last saw her alive on DEC 16, 1920,

and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows:

Myocardial Coronary Disease(Duration) 7 yrs. _____ mos. _____ ds.Contributory
Secondary(Signed) John E. Wadley M. D.
DEC 23, 1920 (Address) 202 E. Capitol St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL Dec 23, 192020 UNDERTAKER G. J. Thrift Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scion, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—occident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 5 1931

BUREAU

WRITE PENCIL WITH UNFADING INK--THIS IS A PERMANENT RECORD

N B Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Burn Mills (No. Boys, Scout Camp)

2 FULL NAME ARTHUR DEWEY

08142 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St.: _____ Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Unknown 1917
(Month) (Day) (Year)

7 AGE 13 yrs. — mos. — ds. or min. ? If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Va.

10 NAME OF FATHER Randolph A. Dewey

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Katherine C. Appenoy

13 BIRTHPLACE OF MOTHER (State or country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Randolph A. Dewey
(Address) Rosslyn Va.

15 Filed 7-4-1936 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 4 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 4 1930 to July 4 1930, that I last saw him live on July 4 1930, and that death occurred on the date stated above at 3:45 p.m.

The CAUSE OF DEATH * was as follows:

Drowning, following acute indigestion, probably cardiac dilatation

Under water 1 1/2 minutes yrs. mos. ds.

Contributory the large meal before
Secondary entering water (Duration) yrs. mos. ds.

(Signed) Wm. A. Shannon M. D.

July 4 1930 (Address) 113-Cornell St. Takoma Park, D.C.
State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death about 10 yrs. mos. ds. In the about 10 State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Rosslyn Va.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington D.C. July 4, 1930

20 UNDERTAKER ADDRESS

W. R. Humphrey, Jr. Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

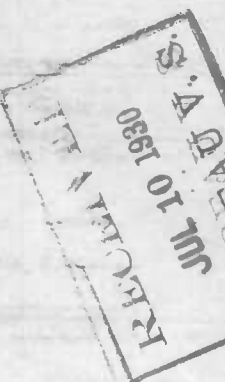
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Fitter-or-Planter, Physician, Compositor, Architect, Boatswain-engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Tranema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A: the data is essential and must be obtained before the certificate is permanently filed.



1 PLACE OF DEATH

County

Montgomery

15139

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

Village or City

Dickerson

(No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

William Harrison Dickerson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

January 29th, 1868
(Month) (Day) (Year)

7 AGE

42 yrs. 10 mos. 15 ds. or min.?

If LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Wm. H. Dickerson

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Elizabeth E. Trundle

13 BIRTHPLACE OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. H. Dickerson

(Address)

Dickerson Md

15

Filed

Dec 15 1930 M. P. Hillou
Registral

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 14th, 1930.
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from 192 to 192.

that I last saw him alive on 192.

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH * was as follows:

Self inflicted fatal wound

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. H. Smith, M.D.

Dec 14 1930 (Address) Beallsville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Beallsville

DATE OF BURIAL

Dec 16, 1930

20 UNDERTAKER

M. T. Hillou & Sons

ADDRESS

Barnesville

Md

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931

BUREAU

MARGIN RESERVED FOR BINDING

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			04803 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgomery</u>			Registration Dist. No. <u>215</u>	
Village or City <u>Bethesda</u>			St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>David Higgins</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Col.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>September 10, 1843</u> (Month) (Day) (Year)				
7 AGE <u>76</u> yrs. <u>7</u> mos. <u>5</u> ds. or min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Ind</u>				
10 NAME OF FATHER <u>David Higgins</u>				
11 BIRTHPLACE OF FATHER <u>Ind</u>				
12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
13 BIRTHPLACE OF MOTHER _____				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Rosa Higgins</u>				
(Address) <u>Deerwood 2nd</u>				
15 Filed <u>Apr 17 1930</u> <u>J. H. Dixon</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>4/14/1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>4/10/1930</u> to <u>4/14/1930</u> that I last saw him alive on <u>4/13/1930</u> and that death occurred on the date stated above, at <u>10:00 P.M.</u> The CAUSE OF DEATH * was as follows: <u>Supper</u> (Duration) yrs. mos. ds. <u>7</u> Contributory <u>Bunch Pneumonia</u> Secondary <u>Ind</u> (Duration) yrs. mos. ds. <u>5</u> (Signed) <u>J. H. Dixon</u> M. D. <u>4/17/1930</u> (Address) <u>Sandy Sp</u> State the Disease Causing Death, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. _____ In the State yrs. mos. ds. _____ Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>West Zion 2nd</u>			DATE OF BURIAL <u>April 17 1930</u>	
20 UNDERTAKER <u>Roy W Barber</u>			ADDRESS <u>Garthersburg</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Cool mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

RECEIVED

JUN 7 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL tetionitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Silver Spring (No. *956-Silver Spring*)

2 FULL NAME

*Ditzler, John Henry*STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *214*

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

*W*5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
married

6 DATE OF BIRTH

Sept 28, 1855
(Month) (Day) (Year)

7 AGE

75 yrs. 1 mos. 18 ds. or *min.?*
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Bricklayer

(b) General nature of industry business, or establishment in which employed or (employer)

none

9 BIRTHPLACE

(State or country)

Cincinnati, Ohio

10 NAME OF FATHER

Ditzler, Christian Hoke

11 BIRTHPLACE OF FATHER

(State or country)

Pa. U.S.A.

12 MAIDEN NAME OF MOTHER

Bricker, Louisa

13 BIRTHPLACE OF MOTHER

(State or country)

Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas W. Ditzler

(Address)

756 Silver Spring Ave. Silver Spring, Md.

15 Filed

*Nov. 16, 1920**J. E. Dudley Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 15, 1920
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*Nov 14, 1920 to Nov 15, 1920,*that I last saw him alive on *Nov. 14, 1920*and that death occurred on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH * was as follows:

Angina Pectoris(Duration) *1* yrs. mos. ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

C. W. Mitchell

M. D.

Nov 15, 1920 (Address) *Silver Spring, Md.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Washington D.C.

DATE OF BURIAL

Nov 18, 1920

20 UNDERTAKER

W. W. Chambers Co

ADDRESS

400 Chapin St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

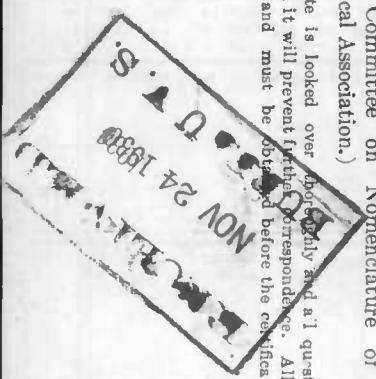
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired—6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over *thoroughly* and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be *checked* before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Montgomery*STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *216*

Village or City

Cabin John

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Annie Elison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

yes married

6 DATE OF BIRTH

unknown, 1867
(Month) (Day) (Year)

7 AGE

63 yrs. *unknown* mos. ds. or min.?

If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Hammond Va

10 NAME OF FATHER

John Collins

11 BIRTHPLACE OF FATHER

(State or country)

Hammond Va

12 MAIDEN NAME OF MOTHER

Emma Linn

13 BIRTHPLACE OF MOTHER

(State or Country)

Hammond Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Peter Elison

(Address)

Cabin John Md

15

Filed *Feb 5* 19*30**Benj. C. Perry*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

February 3, 19*30*
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Nov 1, 1929, to *Feb 3*, 1930.that I last saw him alive on *Feb 1*, 1930.and that death occurred on the date stated above, at *3.30 a.m.*

The CAUSE OF DEATH * was as follows:

Acute Nephritis(Duration) *3* yrs. *1* mos. *1* ds.Contributory
Secondary(Signed) *P. Elison* M. D.*Feb 5*, 1930 (Address) *1185 N. H. Ave*

*State the cause of death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death *1* yrs. *1* mos. *1* ds.In the State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*#10 Cabin Johns. Md.**Feb 5*, 19*30*

20 UNDERTAKER

ADDRESS

W. R. Penney *Rockville*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugstician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Genile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 4 1930

BUREAU V. S.

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1 PLACE OF DEATH

County

Montgomery

Village or City

Silver Spring

(No.)

8512 Cedar

St.

Ward

Registration Dist. No.

214

STATE OF MARYLAND
CERTIFICATE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ida C. Dodge

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Widowed

6 DATE OF BIRTH

October 11, 1851

(Month)

(Day)

(Year)

7 AGE

78 yrs. 4 mos. 12 ds.

If LESS than
1 day hrs.
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

U.S. Government Clerk (Retired)

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Joseph Collins

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Catherine Collins

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Nevils

(Address)

8512 Cedar St.

15

Filed Feb 23, 1930

J. S. Wadsworth
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 23, 1930

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from

Feb 21, 1930 to Feb 23, 1930

that I last saw her alive on Feb. 22, 1930

and that death occurred on the date stated above, at 4⁰⁰ a.m.

The CAUSE OF DEATH * was as follows:

Chronic Valvular Heart Disease (mitral and aortic insufficiency)

(Duration) 5 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) H. H. Harwell M. D.

Feb 23, 1930 (Address) 925 ...

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenwood

2/25, 1930

20 UNDERTAKER

ADDRESS

Donald K. Tatten

Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 5 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Mtzi</u>		12548		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Kensington</u> (No. _____)		St. _____ Ward _____		Registration Dist. No. <u>214</u>	
2 FULL NAME <u>Mary Inez Dodge</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>F</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Oct 17 1930</u> (Month) (Day) (Year)					
7 AGE <u>78</u> yrs. <u>0</u> mos. <u>7</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>N.Y.</u>					
10 NAME OF FATHER <u>George Dodge</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>N.Y.</u>					
12 MAIDEN NAME OF MOTHER <u>Mary Crocker</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>N.Y.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. Charles H. Dandson</u> (Address) <u>Kensington</u>					
15 Filed <u>Oct 25 1930</u> <u>W. J. Lewis</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct 24 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Oct 14 1930</u> to <u>Oct 24 1930</u> that I last saw her alive on <u>Oct 24 1930</u> and that death occurred on the date stated above, at <u>11:30 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Pulmonary Tuberculosis</u> (Duration) <u>20</u> yrs. <u>0</u> mos. <u>0</u> ds. Contributory <u>Exhaustion</u> Secondary (Duration) <u>6</u> yrs. <u>0</u> mos. <u>10</u> ds. (Signed) <u>W. J. Lewis</u> M. D. <u>Oct 25 1930</u> (Address) <u>Kensington</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Ft. Lincoln Md</u>				DATE OF BURIAL <u>Oct 27 1930</u>	
20 UNDERTAKER <u>W. K. Humphrey</u>				ADDRESS <u>Rockville</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic; cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Tetionaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 7 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

05693

STATE OF MARYLAND
CERTIFICATE OF DEATHHome for Aged and Orphans Registration Dist. No. 918Village or City Gaithersburg (No. _____)
Gaithersburg, Md. St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME Lucy Dodson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Sept. 24, 1853, 1
(Month) (Day) (Year)

7 AGE 76 yrs. 7 mos. 13 ds. or _____ min.?
If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Va.

10 NAME OF FATHER Ignatius Dodson

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy Barker

13 BIRTHPLACE OF MOTHER (State or country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Supt., Home for aged & orphans(Address) Gaithersburg, Md.
15 Filed May 19 1930 Richard Hark Etkin
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 17, 1930, 192_____
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from not attended to _____, 192_____
died suddenly
that I last saw him alive on _____, 192_____.

and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH * was as follows:
Acute cardiac dilatation(Duration) 15 min. mos. _____ ds. _____Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds. _____

(Signed) F. J. Brachart M. D.
5/19/30 192____ (Address) Gaithersburg

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients & Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. _____
In the State _____ yrs. _____ mos. _____ ds. _____

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Gaithersburg DATE OF BURIAL May 18, 30, 19____

20 UNDERTAKER F. J. Brachart ADDRESS Gaithersburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonium, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death, 29 ds.; *Brochopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemic" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 7 1920

BUREAU V. R.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

08143

(153)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 216

Village or City Chevy Chase Md. No. 4523 Stanford St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Ann Dorn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH March 21, 1863, 1 (Month) (Day) (Year)

7 AGE 67 yrs. 3 mos. 18 ds. or min. LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Philida. Pa.

10 NAME OF FATHER John Kraus

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Spindler

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Aimee M. Byron

(Address) 4523 Stanford St., Chevy Chase, Md.

15 Filed July 9th 1930 Chase, Md. Benj. O. Perry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 9, 1930 (Month) July (Day) 9 (Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from 1917 192 to Present time 192

that I last saw him alive on July 5, 1930, 192

and that death occurred on the date stated above, at 6 a. m.

The CAUSE OF DEATH * was as follows:

Septicemia of the
fastidious organism of the
Right arm and shoulder
(Duration) yrs. mos. 14 ds.

Contributory Cellulitis of arm & shoulder

(Duration) yrs. mos. 14 ds.

(Signed) H. H. Strind M. D.

July 8, 1930 (Address) 1835 Eyado Rd

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Martinsburg, West Va. DATE OF BURIAL July 10, 1930

20 UNDERTAKER The S. B. Hines Co. ADDRESS Wash. D. C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: (*Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

AUG 5 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

MARGIN RESERVED FOR BINDING
WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Frederick

06824

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217Village or City Wiley (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

² FULL NAME Arthur J. Halsey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 2/15/1881
(Month) (Day) (Year)

7 AGE 49 yrs. 4 mos. 14 ds. or min.? If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Stn.
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ms.

10 NAME OF FATHER Henry Halsey

11 BIRTHPLACE OF FATHER (State or country) Ms.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ada J. Halsey(Address) Gettysburg, Md.

15 Filed June 29 1930 C. S. Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6/29/1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 6/27/1930 to 6/29/1930
that I last saw him alive on 6/29/1930

and that death occurred on the date stated above, at 6 P m.
The CAUSE OF DEATH * was as follows:

Acute Meningeal Infection

(Duration) 6 yrs. 6 mos. 5 ds.
Contributory Bronchitis
Secondary

(Signed) John J. Halsey M. D.
6/29/1930 (Address) Sandy Spring

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 6 yrs. 6 mos. 5 ds. In the State 6 yrs. 6 mos. 5 ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Wiley DATE OF BURIAL July 230

20 UNDERTAKER Wiley ADDRESS Wiley

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Fireman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschemia," "Anemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

M, this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUL 3 1930
BUREAU

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH

County Martinsburg

05694 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

Village or City Martinsburg (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

² FULL NAME Frederick moss Dorsey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH May 20, 1869
(Month) (Day) (Year)

7 AGE 61 yrs. 4 mos. 20 ds. or min. If LESS than 1 day ____ hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Marchant
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Walter Dorsey

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary O'Farrell

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charlotte Dorsey

(Address) Martinsburg Ind.

15 Filed May 19, 1930 E. White Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 17, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from no physician in attendance, 192____, that I last saw him alive on, 192____, and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH * was as follows: acute gastritis
bleed

(Duration) unknown yrs. ____ mos. ____ ds.

Contributory Secondary Hematemesis
(Duration) ____ yrs. ____ mos. 5 min. ds.

(Signed) E. White M. D.
May 19, 1930 (Address) E. White

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, it not at place of death? _____

Former or Usual residence _____

19 PLACE OF BURIAL OR REMOVAL Martinsburg Ind. DATE OF BURIAL May 21, 1930

20 UNDERTAKER H. M. Snyder ADDRESS Mt. Airy

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 8 1900
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

(92)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *217*Village or City *Bellevue* (No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME in- stead of street and number.)

2 FULL NAME *Sir Anna Elsey Montgomery*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

*2**9**1872*

(Month)

(Day)

(Year)

7 AGE

58

yrs.

10

mos.

16

ds.

IF LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Wm.

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

MD

10 NAME OF FATHER

Chas Smith

11 BIRTHPLACE OF FATHER (State or country)

MD

12 MAIDEN NAME OF MOTHER

Johanna Epp

13 BIRTHPLACE OF MOTHER (State or Country)

MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Matthews

(Address)

Road 2nd

15

Filed *Dec 24**1913**C. B. Barnes*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*12/23/**1930*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*12/10/**1930*to *12/23/**1930*that I last saw him alive on *12/23/*, 1930,and that death occurred on the date stated above, at *11 P.* m.

The CAUSE OF DEATH * was as follows:

Cholecyctitis(Duration) yrs. mos. *12* ds.

Contributory Secondary

Pulmonary Embolism(Duration) yrs. mos. *1* ds.

(Signed)

M. D.

M. D.

*12/24/**1930*

(Address)

Sandy Sp

*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

16

ds.

In the State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Bookeville Md**Dec 26, 1930*

20 UNDERTAKER

ADDRESS

*W. E. & Son**Sykesville Md*

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 3 1931

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Mt. Damascus (No. _____)

2 FULL NAME Leroy Dorsey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE C 5 SINGLE, MARRIED, WID. WED. OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec. 13, 1930
(Month) (Day) (Year)

7 AGE 7 yrs. 7 mos. 12 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Richard Dorsey

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Dunmark

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Dorsey
(Address) R.D. Mt. Airy, Md.

15 Filed July 22, 1930 Della W. Beall
Deputy Registrar

08144 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 211

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 23, 1930 to July 25, 1930, that I last saw him alive on July 25, 1930, and that death occurred on the date stated above, at 9 p.m.
The CAUSE OF DEATH was as follows: Gastro-enteritis, acute

(Duration) _____ yrs. _____ mos. 4 ds.
Contributory Un-hygienic surroundings
Secondary

(Signed) George M. Boyer M.D.
July 26, 1930 (Address) D. Damascus, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For hospitals, institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Friendship Cemetery DATE OF BURIAL July 26, 1930

20 UNDERTAKER J. B. Beall, Inc. ADDRESS Damascus, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (c) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For-man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Food mill*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc.; *Coronoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

BUREAU

MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

64448

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

Village or City

Marfanburg

St.:

Ward:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Stillbirth

Dorsey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Unknown C

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Apr 4, 1930
(Month) (Day) (Year)

7 AGE

0 yrs. 0 mos. 0 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

not any

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Marfanburg

10 NAME OF FATHER

Samuel Dorsey

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Savanna Briggs

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Theresa Dorsey

(Address)

Dorsey Rd

15 Filed

Apr 5 1930 E. W. White

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 4, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

No physician in 192...
that I last saw him alive on 11/1/192...

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH * was as follows:

aborted by mother at 2 mos

Contributory
Secondary(Duration) yrs. mos. ds.
(Signed) E. W. White M. D.
Apr 5 1930 (Address) Prohault

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

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MAY 6 1930
BUREAU OF VITAL STATISTICS

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *shop pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE HERE WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Martinsburg No. _____

2 FULL NAME still birth

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX undebund 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Dec 1st 1930
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Samuel Dorsey

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Savina Diggs

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Savina Diggs
(Address) Dickerson St

15 Filed Dec 1 1930 E. W. White
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 1st 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 1st 1930 to Dec 1 1930
that I last saw him alive on Dec 1 1930

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

Spontaneous abortion

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary unknown

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. W. White M. D.
Dec 1 1930 (Address) Providence

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archdeacon, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931

BUREAU

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1 PLACE OF DEATH

County

Montgomery

Village or City

Silver Spring

(No.)

2 FULL NAME

Mrs Emeline Doty

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

widowed

6 DATE OF BIRTH

Feb 18, 1852
(Month) (Day) (Year)

7 AGE

78 yrs. 9 mos. 24 ds. or min.

If LESS than
1 day hrs.
1 day hrs.
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Coles Creek, Pa.

10 NAME OF FATHER

John Moore

11 BIRTHPLACE OF FATHER

(State or country)

Coles Creek, Pa.

12 MAIDEN NAME OF MOTHER

Amanda Kile

13 BIRTHPLACE OF MOTHER

(State or country)

Coles Creek, Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs A. P. Kennedy

(Address)

819 Philadelphia Ave
Silver Spring, Md

15 Filed

Dec 12 1930

J. S. Wadsworth
Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 12, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Dec 8, 1930 to Dec 12, 1930.

that I last saw him alive on Dec 11, 1930.

and that death occurred on the date stated above, at 2:30 A.M.
The CAUSE OF DEATH * was as follows:

Pneumonia, lobular

(Duration) yrs. mos. 5 ds.

Contributory
Secondary

myocarditis

(Duration) yrs. 9 mos. ds.

(Signed)

W. Mitchell

M. D.

Dec 12, 1930 (Address) W. Mitchell

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington d. C. Dec 12, 1930

20 UNDERTAKER

Marion W. Hyatt Co. 1300 N. 3rd St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

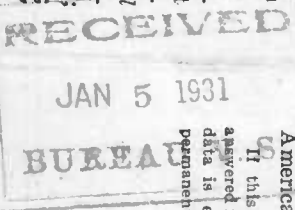
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinter, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer retired 6 yrs.* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group Typhoid fever (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County mont

Village or City Olney - (No. Mont Co Gen Hoops) St. 178 Ward 0565 (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME Tom H. Dore Registration Dist. No. 217

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) wed

6 DATE OF BIRTH April 16, 1955
(Month) (Day) (Year)

7 AGE 75 yrs. 4 mos. 28 ds. If LESS than 1 day ___ hrs. or ___ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed or (employer) laborer

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Wm H Dore

11 BIRTHPLACE OF FATHER (State or country) MO

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or Country) 11

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tom H Dore
(Address) Rockville RFD

15 Filed Jan 18 1980 C. S. Barnsley
Registrar

for record

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 14, 1980
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 27, 1979, to Jan 14, 1980, that I last saw him alive on Jan 14, 1980.

and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH * was as follows:

Severe burns of body & limbs: due to conflagration, engine

(Duration) 1 yrs. 17 mos. 17 ds.
Contributory Cerebral Embolism
Secondary

(Signed) C. S. Barnsley M. D.
Jan 18 1980 (Address) Sandy Spring

*State the 1 is use Causing Death, or, 1 deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 17 mos. 17 ds. In the Life State 1 yrs. 17 mos. 17 ds.

Where was disease contracted, if not at place of death? former Residence

Former or usual residence Rockville RFD

19 PLACE OF BURIAL OR REMOVAL Scotland Cem. Mont Co DATE OF BURIAL Jan 19, 1980

20 UNDERTAKER Geo Snowden ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated, thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 5 1930
BUREAU V 8

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Scotland near Rockville. (No. 90)

2 FULL NAME Frank Dover

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 212

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Unknown
(Month) (Day) (Year)

7 AGE about 82? yrs. mos. ds. or min. If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Retail Merchant
(b) General nature of industry business, or establishment in which employed or (employer) Grocers & Merchandise

9 BIRTHPLACE (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Elbert Slaggett

(Address) R. F. D. Rockville Maryland

15 Filed 12-28 1930 Mrs. W. T. Riet
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 26, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1928 to 192

that I last saw him alive on about 4 P. M.

and that death occurred on the date stated above, at about 4 P. M.

The CAUSE OF DEATH * was as follows:

Chronic Myocarditis

(Duration) yrs. mos. ds.

Contributory Secondary Unknown

(Duration) yrs. mos. ds.

(Signed) A. J. Probst M. D.
Dec 27 1930 (Address) Rockville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Holy Rood Cem. Wash. D.C. Dec 29, 1930

20 UNDERTAKER ADDRESS

Wm. Reuben Pumphrey Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 6 1931

BUREAU V. S.

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Name Film 8230 6-20-58ge

1 PLACE OF DEATH

County MontgomeryVillage or City Brown's Corner (No. 100)2 FULL NAME Ada M. Brown

04449

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 212

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married6 DATE OF BIRTH Feb. 2nd, 1894 (Month) (Day) (Year)7 AGE 36 yrs. 2 mos. 16 ds. or min. If LESS than 1 day hrs.8 OCCUPATION (a) Trade, profession or particular kind of work Housewife (b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Md.10 NAME OF FATHER Albert Black11 BIRTHPLACE OF FATHER (State or country) Md.12 MAIDEN NAME OF MOTHER Sarah Chiles13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Brown
(Address) Brown's Corner Md.15 Filed April 19 1930 O. S. Barnes
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 18, 1930 (Month) 5 (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 6, 1930, to April 18, 1930.that I last saw her alive on April 17, 1930and that death occurred on the date stated above, at 1 A m.

The CAUSE OF DEATH * was as follows:

Lobar PneumoniaContributory Secondary (Duration) yrs. mos. 6 ds. Bronchitis(Signed) J. R. Hays M. D. April 19 1930 (Address) Letter Spring Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Union Cemetery Baltimore DATE OF BURIAL 4/19/3020 UNDERTAKER Royd Kaiser ADDRESS Letter Spring Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

her issue

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

06825 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2/3

Village or City In Potomac (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles Raymond Dray

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Oct 8, 1908
(Month) (Day) (Year)

7 AGE 22 yrs. 6 mos. 21 ds. or LESS than 1 day ____ hrs. ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Sergeant Marine Corps
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ohio

10 NAME OF FATHER A. G. Dray

11 BIRTHPLACE OF FATHER (State or country) Ohio

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul F. Findley
(Address) 8th & 28th West St. E

15 Filed 6-30 1930 W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192, and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH * was as follows:
accidental drowning while swimming in O & O Canal
in deeply mud
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Signed) C. E. Hawkins M. D.
(Address) Rockville Md
(Duration) ____ yrs. ____ mos. ____ ds.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington St. 7, 4, 1930

20 UNDERTAKER ADDRESS

Harner & Thompson Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

*Completed by Mrs. John J. C. E. Hanks
with 7/26/30*

RECEIVED
JUL 7 1930
BUREAU OF VITALS

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Glen Echo Hgts No. _____2 FULL NAME Kate L. DresserSTATE OF MARYLAND
CERTIFICATE OF DEATH

09375

(49)

Registration Dist. No. 216

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>fem.</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widow</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH <u>Feb. 17th</u> , 18 <u>52</u> (Month) (Day) (Year)
--

7 AGE <u>78</u> yrs. <u>5</u> mos. <u>19</u> ds. or _____ min.?	IF LESS than 1 day _____ hrs.
--	-------------------------------

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____
--

9 BIRTHPLACE (State or country) <u>New York</u>
--

10 NAME OF FATHER <u>Winnie</u>

11 BIRTHPLACE OF FATHER (State or country) <u>New York</u>

12 MAIDEN NAME OF MOTHER <u>unknown</u>
--

13 BIRTHPLACE OF MOTHER (State or Country) <u>New York</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. Orndorff(Address) Glen Echo Hgts. Md.15 Filed Aug 6 1930 Benj. C. Perry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 6, 19230
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 20 19230 to Aug. 6 19230that I last saw her alive on August 6 19230and that death occurred on the date stated above, at 10:20 m.

The CAUSE OF DEATH * was as follows:

Carcinoma - bladder.Contributory Secondary
Chr. arteriosclerosis (Duration) _____ yrs. _____ mos. _____ ds.(Signed) E. P. Bauerfeld M. D.
Aug 6 19230 (Address) Berkesda Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Cedar Hill, Wash. D. C. DATE OF BURIAL Aug. 8, 193020 UNDERTAKER The S. H. Hines Co. ADDRESS 2901-14th St. Wash. D. C.

CERTIFICATE OF DEATH

U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite), *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Ehaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL SEPTICÆMIA," "PERIPERAL PERITONITIS," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Resolvent wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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1 PLACE OF DEATH
County Montgomery

09376

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Iden Echo (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Bernard A. Duke

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH November 30, 1870
(Month) (Day) (Year)

7 AGE 59 yrs. 8 mos. 27 ds. or _____ min.?
If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed or (employer) Real Estate

9 BIRTHPLACE (State or country) New York
10 NAME OF FATHER B. A. Duke

11 BIRTHPLACE OF FATHER (State or country) New York
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (State or Country) IL

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Duke
(Address) Iden Echo, Md

15 Filed 8/28/30 192 Berj. C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 27th, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug. 25, 1930 to Aug 27, 1930
that I last saw him alive on August 27, 1930

and that death occurred on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH * was as follows:

Epileptic convulsions

Contributory Secondary (Duration) 3 mos. 3 ds.
Epilepsy, Jacksonian
about

(Signed) Aug 27, 1930 (Duration) 4 yrs. - mos. - ds.
Aug 27, 1930 (Address) Bethesda, Md M. D.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was death contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Potomac Md. DATE OF BURIAL Aug 30, 1930

20 UNDERTAKER Harold C. Pughley ADDRESS Rockville, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
SEP 3 1930
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montg.</u>		12549		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Saithurstburg</u> (No. <u>178</u>)		Registration Dist. No. <u>218</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Gas. Wm. Duke</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>m.</u>	4 COLOR OR RACE <u>col.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Oct. 14</u> , 1922 (Month) (Day) (Year)					
7 AGE <u>8</u> yrs. <u>0</u> mos. <u>6</u> ds. If LESS than 1 day. hrs. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>none</u>					
9 BIRTHPLACE (State or country) <u>Ind.</u>					
PARENTS					
10 NAME OF FATHER <u>Michael Duke</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Ky.</u>					
12 MAIDEN NAME OF MOTHER <u>Lorraine Curtis</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ind.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lorraine Duke</u> (Address) <u>Saithurstburg</u>					
15 Filed <u>Oct 20, 1930</u> <u>W. C. Tucker</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct. 19</u> , 192 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>1922</u> to <u>1923</u> , that I last saw him <u>active on</u> <u>Oct 19</u> , 192 <u>30</u> , and that death occurred on the date stated above, at <u>9:00</u> a.m. The CAUSE OF DEATH * was as follows: <u>Dead when I saw him.</u> <u>Asphyxiated from smoke</u> <u>when house caught fire.</u> (Duration) (Yrs.) (Mos.) (Ds.)					
Contributory Secondary (Signed) <u>Stanley W. Barber</u> M. D. <u>10/21</u> 192 <u>30</u> (Address) <u>Saithurstburg</u> *State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>3</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>3</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? <u>same</u> Former or usual residence <u>same</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Saithurstburg Ind</u> DATE OF BURIAL <u>10/22, 1930</u>					
20 UNDERTAKER <u>E. C. Sartner</u> ADDRESS <u>Saithurstburg</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

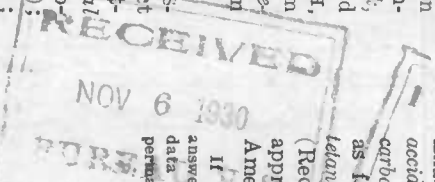
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MTVillage or City Silver Spring MD (No. _____)2 FULL NAME Laura M Duvall

06826

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214

(44)

St. _____ Ward) _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married6 DATE OF BIRTH Oct 12 1858

(Month) (Day) (Year)

7 AGE 71

... yrs. ... mos. ... ds. or ... min. ?

If LESS than 1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE

(State or country) MD.

PARENTS

10 NAME OF FATHER John W. Duvall

11 BIRTHPLACE OF FATHER

(State or country) MD.12 MAIDEN NAME OF MOTHER Elizabeth McElroy

13 BIRTHPLACE OF MOTHER

(State or country) MD.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benjamin Duvall(Address) 8711 Green Gable Woodmont

15

Filed June 11 1930J. E. Wadsworth
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 11 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 1 1928 to June 11 1930that I last saw her alive on June 11 1930and that death occurred on the date stated above, at 7:30 m.

The CAUSE OF DEATH was as follows:

Cancer of stomach and duodenum(Duration) 1 yrs. 6 mos. 0 da.Contributory Secondary Myocarditis(Duration) 6 mos. 0 da.(Signed) W. R. Hayner M.D.June 11 1930 (Address) Silver Spring MD.

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.... yrs. mos. da.

In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Detroit MD.DATE OF BURIAL June 13 193020 UNDERTAKER W. W. ClementsADDRESS 1400 Chapin St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as: *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease causing death, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus: *Farmer* (*retired & free*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. Of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 10 1920
BUREAU OF

WRITE IN ALL CAPS, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Emory Grove

2 FULL NAME Mary C. D. Durrell

03095 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Don't know, 1 _____ (Month) (Day) (Year)

7 AGE 57 (7) yrs. _____ mos. _____ ds. or _____ min. If LESS than 1 day _____ hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work House work (b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry Warfield

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Mitchell

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Durrell

(Address) Fredericksburg, Va.

15 Filed March 31 1930 Paul Chase Stinson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March - 30, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from September 1929 to March 30, 1930

that I last saw her alive on March 22, 1930

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH * was as follows: Cerebro-spinal syphilis

(Duration) 4 yrs. _____ mos. _____ ds.

Contributory Secondary _____

(Signed) H. C. Miller M. D. 3-31-1930 (Address) Fredericksburg, Va.

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Emory Grove DATE OF BURIAL 4/2/30

20 UNDERTAKER H. C. Humphrey ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by falling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 5 1930
BUR

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County

Village or City

FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED, married
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

November 22, 1854
(Month) (Day) (Year)

7 AGE

26 yrs. mos. 11 ds. or min.?

If LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Real Estate Agent

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

Dec 4 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

12 / 7, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from 7 / 28 1930 to 12 / 3 1930,

that I last saw him alive on 12 / 3 1930.

and that death occurred on the date stated above, at 10:35 P. M.

The CAUSE OF DEATH * was as follows:

Carcinoma of Esophagus and
metastatic disease.

(Duration) yrs. 7+ mos. ds.

Contributory
SecondaryBronchopneumonia
+ Lung Abscess.

(Signed)

J. I. Moss M. D.

12 / 3 1930 (Address) Takoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 4 mos. 23 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1827 M. Wash, D.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D.C.

12 / 5, 1930

20 UNDERTAKER

ADDRESS

John R. Wright Co

1337-10 NW

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

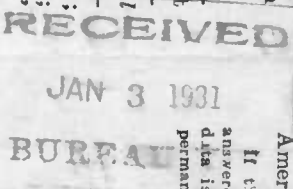
(Approved by U. S. Census and American Public
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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds., Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			01802 STATE OF MARYLAND CERTIFICATE OF DEATH		Registration Dist. No. 212	
County <u>Montgomery</u>			St. <u>14-2</u>		Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
Village or City <u>Bearsden</u>						
2 FULL NAME <u>Joseph B. P. Wyson</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>Feb 10</u> , 193 <u>0</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>Feb - 10</u> , 18 <u>64</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 9</u> , 192 <u>9</u> to <u>Feb 10</u> , 193 <u>0</u> , that I last saw him alive on <u>Feb 10</u> , 193 <u>0</u> , and that death occurred on the date stated above, at <u>10-40 P.M.</u> , The CAUSE OF DEATH * was as follows: <u>arteriosclerosis</u>			
7 AGE <u>66</u> yrs. - <u>9</u> mos. <u>9</u> ds. or min.?			If LESS than 1 day ___ hrs. ___ min.			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer)			Contributory (Duration) <u>3</u> yrs. ___ mos. ___ ds. Secondary <u>arteriosclerosis</u>			
9 BIRTHPLACE (State or country) <u>Maryland</u>			(Duration) ___ yrs. ___ mos. <u>3</u> ds.			
PARENTS	10 NAME OF FATHER <u>Benj. P. Wyson</u>		(Signed) <u>E. W. White</u> M. D. <u>Feb 10</u> 193 <u>0</u> (Address) <u>Bearsden</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
	12 MAIDEN NAME OF MOTHER <u>Catherine Pyles</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>		Where was disease contracted, if not at place of death? Former or usual residence			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. Wyson</u> (Address) <u>Boyd Md</u>						
15 Filed <u>Feb 13</u> 193 <u>0</u> <u>E. W. White</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Bearsden, Md.</u>		DATE OF BURIAL <u>2/13. 1930</u>	
			20 UNDERTAKER <u>W. D. Hillman & Son</u>		ADDRESS <u>Bearsden</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

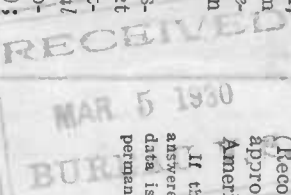
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

(157)

04450

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217Village or City Olney, Maryland (No. Montgomery Co. Gen'l Hospital St.

Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Dorothy Eader

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
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6 DATE OF BIRTH
May 27, 1889
(Month) (Day) (Year)7 AGE
42 yrs. 10 mos. 18 ds. or min. If LESS than 1 day hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)9 BIRTHPLACE
(State or country) Montgomery County, Md.10 NAME OF FATHER
William Dwyer11 BIRTHPLACE OF FATHER
(State or country) Baltimore, Maryland12 MAIDEN NAME OF MOTHER
Rachel Musgrove13 BIRTHPLACE OF MOTHER
(State or country) Ellicott City, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Eader(Address) Gaithersburg, Md.15 Filed April 4 1930 Patricia S. Kennedy
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
April, 14 (Month) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from 4/5 19230 to 4/14 19230that I last saw her alive on 4/14 19230,and that death occurred on the date stated above, at 7:45 A m.
The CAUSE OF DEATH * was as follows:Sanguinous Stomatitis(Duration) yrs. mos. 14 ds.Contributory Acute Paratyphoid
Secondary(Duration) yrs. mos. 10 ds.(Signed) Mrs. Eader M. D.April 14, 19230 (Address) Sandy Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Gaithersburg, Montgomery County, Md.

19 PLACE OF BURIAL OR REMOVAL

Gaithersburg DATE OF BURIAL Apr 16, 1930

20 UNDERTAKER

Gartner ADDRESS Gaithersburg, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

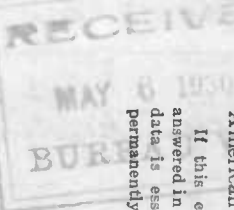
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scullion, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomati), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Montgomery

12550

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 2/3Village or City Montrose, Md. No. _____

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Easterbrook

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
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6 DATE OF BIRTH
November 21, 1861
(Month) (Day) (Year)7 AGE
68 yrs. 10 mos. 13 ds. or LESS than 1 day ____ hrs. ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed or (employer) _____9 BIRTHPLACE
(State or country) England10 NAME OF FATHER James Easterbrook11 BIRTHPLACE OF FATHER
(State or country) England12 MAIDEN NAME OF MOTHER Mary Pearce13 BIRTHPLACE OF MOTHER
(State or Country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Mertie R. Easterbrook(Address) Montrose, Md.15 Filed 10-4 1930 Mrs. W. T. Pratt

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
October 4, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from
July 1930 to October 3, 1930
that I last saw him alive on October 3, 1930and that death occurred on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH * was as follows:

Carcinoma of stomach
with metastases to liver
(to my knowledge)
(Duration) ____ yrs. ____ mos. ____ ds.Contributory
Secondary(Signed) J. H. Hartley M. D.
Oct. 4, 1930 (Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Syracuse N.Y. DATE OF BURIAL Oct. 6, 193020 UNDERTAKER Warner C. Humphrey ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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NOV 5 1930

BUREAU

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PLACE OF DEATH

County Montgomery

04451

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214Village or City Silver Spring (No. 8413 Grove)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Leon Guy Ellis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH June 9, 1894
(Month) (Day) (Year)7 AGE 35 yrs. 10 mos. 9 ds. or LESS than 1 day, ____ hrs. ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Accountant
(b) General nature of industry, business, or establishment in which employed or (employer) Alien Property Custodian's Office9 BIRTHPLACE (State or country) Pennsylvania10 NAME OF FATHER William Henry Ellis11 BIRTHPLACE OF FATHER (State or country) Pennsylvania12 MAIDEN NAME OF MOTHER Elizabeth Kirby13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. L. G. Ellis(Address) 8413 Grove St. Silver Spring, Md15 Filed April 20, 1930 J. S. Dudley Jr.
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 18th, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from January 1, 1930 to April 18, 1930
that I last saw him alive on April 18, 1930and that death occurred on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH * was as follows:

Fibro Sarcoma
(Right Inguinal)(Duration) 3 yrs. ____ mos. ____ ds.Contributory Schrapnell Wound
Secondary right thigh (Incurred in World War)
(Duration) 12 yrs. ____ mos. ____ ds.(Signed) H. H. Howard M. D.
April 18, 1930 (Address) 928 E. 20 Ave. Silver Spring, Md

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence ____

19 PLACE OF BURIAL OR REMOVAL Green Hill Cemetery
Waynesboro Penn DATE OF BURIAL 4/21, 193020 UNDERTAKER W R Pamphrey Jr ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

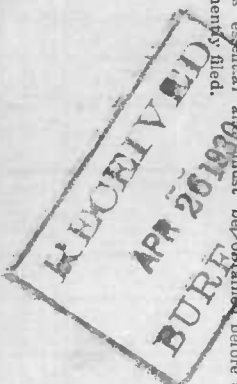
(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Montgomery

09377

(74a)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214Village or City Takoma Park (No. Washington San.adium & Hosp. Ad. St. 103 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Helen C. T. Elliott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>
6 DATE OF BIRTH <u>January 5, 1851</u> (Month) (Day) (Year)		
7 AGE <u>79</u> yrs. <u>8</u> mos. <u>23</u> ds. or <u>LESS than 1 day</u> hrs. min.?		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired.</u> (b) General nature of industry, business, or establishment in which employed or (employer)		
9 BIRTHPLACE (State or country) <u>New York</u>		
PARENTS	10 NAME OF FATHER <u>Mr. Phineas B. Tompkins</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>New York</u>	
	12 MAIDEN NAME OF MOTHER <u>Hannah Caroline Ross</u>	
13 BIRTHPLACE OF MOTHER (State or Country) <u>New York</u>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) San.adium Records
(Address) Takoma Park, Md.15 Filed Aug 28, 1930 J. E. Henderson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 28, 1930

17

I HEREBY CERTIFY, That I attended the deceased from

Aug 11, 1930 to Aug 28, 1930that I last saw her alive on Aug 27, 1930and that death occurred on the date stated above, at 1:41 P. M.

The CAUSE OF DEATH * was as follows:

Similar

(Duration) yrs. mos. ds.

Contributory
SecondaryCerebral Hemorrhage

(Duration) yrs. mos. ds.

(Signed)

D. W. Kress

M. D.

Aug 28, 1930 (Address) Takoma Park, DC

*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death: 0 yrs. 0 mos. 17 ds.In the State: 0 yrs. 0 mos. 17 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3315 Garfield St. Washington, D.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash. D. C.Aug 28, 1930

20 UNDERTAKER

ADDRESS

Jas. Gawler's Son1754 Pavey NW

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marsasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 6 1930

BUREAU OF

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH
County Montgomery

Village or City Takoma Park, Md. Wash. San. & Hosp. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Miss Mary Erickson

12551
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 28 1857
(Month) (Day) (Year)

7 AGE 73 yrs. 2 mos. 12 ds. or 12 min. If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired Gov't Clerk
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Somerville, Tenn.

10 NAME OF FATHER Francis Erickson

11 BIRTHPLACE OF FATHER (State or country) N. J.

12 MAIDEN NAME OF MOTHER Temperance S. Gryant

13 BIRTHPLACE OF MOTHER (State or country) Louisburg, N. J.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records
(Address) Takoma Park Md.

15 Filed Oct 9 1930 J. E. Dudley
Registral

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 9 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1928 to October 9 1930
that I last saw her alive on October 9 1930
and that death occurred on the date stated above, at 640 a.m.

The CAUSE OF DEATH * was as follows:

Paralysis agitans

(Duration) 2 yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. E. Varnum M. D.
192 ____ (Address) Takoma Park Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 8 mos. 2 ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence 3402 16th St. Washington D. C.

19 PLACE OF BURIAL OR REMOVAL Wash. D. C. DATE OF BURIAL Oct 9 1930

20 UNDERTAKER Gos. Sawhorses ADDRESS 734-P. Ave.

STATE OF MARYLAND
CERTIFICATE OF DEATH

DEATH

LOCALITY OF DEATH

NAME AND RESIDENCE OF DECEASED

RECEIVED

NOV 7 1930

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day ____ hrs.
or ____ min.?

8 OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER

(State or country)

12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1920

Registrar

(17)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

Ward)

(If death occurred in
a hospital or institution,
give its NAME in-
stead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from
1930 to 1930, that I last saw him alive on 1930,and that death occurred on the date stated above, at 4 P. m.
The CAUSE OF DEATH * was as follows:Acute Sanguinous
AppendicitisContributory
Secondary

(Signed)

1930 (Address)

*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-
ients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (c) *Salesman*, (b) *Grocery*; (c) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former firebrand 6 yrs.* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Likelihood* avoid use of "Group"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia");

SEP 4 1930

COPY SENT TO LOCAL REGISTRAR

217 DATE 9/29/30

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU U. S.

RECEIVED
OCT 4 1930
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

10532 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX (F) 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH

June 10, 1865
(Month) (Day) (Year)

7 AGE

65 yrs. 2 mos. 21 ds. or 1 day hrs. min.
If LESS than 1 day

8 OCCUPATION

(a) Trade, profession or particular kind of work Housework
(b) General nature of industry business, or establishment in which employed or (employer) Same

9 BIRTHPLACE (State or country)

md.
Henry Zear
md.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

Laura Rickels
md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Ralph E. Echison
Gaithersburg, md.

15

Filed

Sep 3, 1930
Bacul Dav Echison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 1, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 15, 1926 to Sept 1, 1930
that I last saw him alive on Aug 31, 1930

and that death occurred on the date stated above, at 11 a m.
The CAUSE OF DEATH * was as follows:

Carcinoma of
uterus.
(Duration) 2 yrs. — mos. — ds.

Contributory Secondary

(Signed) Stanley W. Barker
2 Sept 1930 (Address) Gaithersburg

*State the Disease Causing Death, or, in deaths from violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 65 yrs. 2 mos. 21 ds. In the State Same yrs. — mos. — ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gaithersburg, md. 3 Sept 1930

20 UNDERTAKER

ADDRESS

E. C. Gardner
Gaithersburg
md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Tenant, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by tartaric acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Rockville (No. 45)

2 FULL NAME George H. B. Evans

0566

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 ~~STATUS~~,
MARRIED,
WIDOWED,
~~OR DIVORCED~~
(Write the word)

6 DATE OF BIRTH Oct 7 1853
(Month) (Day) (Year)

7 AGE 77 3 2 If LESS than
1 day ____ hrs.
____ yrs. ____ mos. ____ ds. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) England

10 NAME OF FATHER England

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Anne Clay

13 BIRTHPLACE OF MOTHER (State or Country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. C. H. Walker
(Address) Rockville, Md.

15 Filed Jan 10 1930 W. L. Davis
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 9 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 10 1929 to Jan 9 1930
that I last saw him alive on Jan 9 1930

and that death occurred on the date stated above, at ____ m.
The CAUSE OF DEATH was as follows:

Carcinoma of the colon
(Duration) 1 yrs. ____ mos. ____ ds.

Contributed by Carcinoma of the colon
Secondarily the colon
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Jan 10 1930 (Address) Rockville, Md.

*State the cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. None

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

14 PLACE OF BURIAL OR REMOVAL Rockville, Md. DATE OF BURIAL Jan 11 1930

15 UNDERTAKER Marine Undertaking Co. ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite: avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Ehaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 7 1930
BUREAU V. S.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Takoma Park (New Washington Sanitarium Hospital)

Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs Mary EwellSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

November 15 1865
(Month) (Day) (Year)

7 AGE

65 yrs. 1 mos. 4 ds. or min. If LESS than 1 day... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Cambridge Md.

10 NAME OF FATHER

Mr. Andrew J. Robinson

11 BIRTHPLACE OF FATHER (State or country)

Cambridge Md.

12 MAIDEN NAME OF MOTHER

Sophie J. Travers

13 BIRTHPLACE OF MOTHER (State or country)

Cambridge Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Buchness(Address) 38 Stricker St Balto Md

15 Filed

Dec 19 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

December 19 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from November 7 1930 to December 19 1930that I last saw her alive on December 19 1930and that death occurred on the date stated above, at 2:40 p.m.

The CAUSE OF DEATH * was as follows:

Malignancy of left lung

Contributory Secondary

(Signed) J. B. Moore M. D.
12/19/30 (Address) Takoma Park Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 1 mos. 20 ds. In the State 0 yrs. 1 mos. 20 ds.

Where was disease contracted, if not at place of death? Hotel Rennart, Baltimore MdFormer or usual residence Hotel Rennart, Baltimore Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cambridge Md 12/21 1930

20 UNDERTAKER

ADDRESS

Robert Brooks & Son Baltimore

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farm or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia";

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Muscles* (disease causing death), *23 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little diligence is essential and must be obtained before the certificate is permanently filed.

JAN 3 1911
BUREAU V. B.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery
Village or City Takoma Park Md. Wash. San & Hosp Ward 223
2 FULL NAME Mrs Louella Farney
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE white
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) MARRIED
6 DATE OF BIRTH March 26, 1864
(Month) (Day) (Year)
7 AGE 66 yrs. 5 mos. 11 ds. or min.?
8 OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed or (employer)
9 BIRTHPLACE (State or country) Ohio
10 NAME OF FATHER Henry Wickline
11 BIRTHPLACE OF FATHER (State or country) Virginia
12 MAIDEN NAME OF MOTHER Mary Slagle
13 BIRTHPLACE OF MOTHER (State or country) Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records
(Address) Takoma Park Md

15 Filed Sept 6 1930 Dr. C. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 6, 1930
(Month) (Day) (Year)
17 I HEREBY CERTIFY, That I attended the deceased from August 27, 1930 to Sept 6, 1930, that I last saw her alive on Sept 6, 1930, and that death occurred on the date stated above, at 6 P m.
The CAUSE OF DEATH * was as follows:

Pulmonary Embolus

Contributory cholecystectomy (Duration) 1 yrs. 1 mos. 1 ds.
Secondary for chronic cholecystitis (Duration) 4 mos. 4 ds.

(Signed) Dr. C. Rogers M. D.
Sept 6 1930 (Address) Takoma Park Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 11 ds. In the State 0 yrs. 0 mos. 11 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 11 Lyncamore Ave The Ph Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bedard Hill Cemetery Sept 9, 1930

20 UNDERTAKER

ADDRESS

H. B. Nevins Dr. H. J. Gorman

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

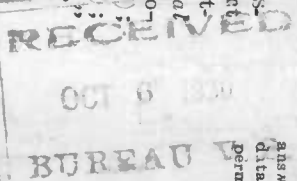
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia," "Lobar pneumonia, Bronchopneumonia ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few details are essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE FULLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

Friendship Heights

Village or City (No. 224 Wootton Ave.

04452

(31)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lillian Parker Farnham

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Feb. 9, 1894
(Month) (Day) (Year)

7 AGE 36 yrs. 2 mos. 0 ds. or min. If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maine

10 NAME OF FATHER John A. P. Farnham

11 BIRTHPLACE OF FATHER (State or country) Maine

12 MAIDEN NAME OF MOTHER Lena H. Parker

13 BIRTHPLACE OF MOTHER (State or Country) Maine

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. P. Farnham(Address) 224 Wootton Ave.

15 Filed Apr. 10 1930 Benj. C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 9th, 1930
(Month) 9 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 25, 1925 to April 9, 19230,

that I last saw her alive on April 8, 19230,

and that death occurred on the date stated above, at 10.55 a.m.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

(Duration) 6 yrs. - mos. - ds.
Contributory Pulmonary hemorrhage
Secondary

(Duration) 1 yrs. - mos. - ds.(Signed) W. A. Teetsbury M. D.

April 9 1930 (Address) 1835 Eye St NW

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yr. mos. ds. In the State yr. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brewer, MaineApr. 11, 1930

20 UNDERTAKER

The S. H. Harris Co. ADDRESS 2901-14th St. N.W.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Coronoma, Sorcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Iamition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

MAY 5 1930
BUREAU OF VITAL STATISTICS

MARGIN RESERVED FOR BINDING

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

06828

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 2-16Village or City Chevy Chase (No. 6410) Connet. Ave. St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Frederick Ernest Farrington

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)
----------------------	---------------------------------	---

6 DATE OF BIRTH
Dec. 15th 1872
(Month) (Day) (Year)7 AGE
57 yrs. 6 mos. 16 ds. or min.?
If LESS than 1 day ____ hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Professor of Chevy Chase School, Educator.
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE
(State or country) Mass.10 NAME OF FATHER
John Henry Farrington11 BIRTHPLACE OF FATHER
(State or country) Scotland.12 MAIDEN NAME OF MOTHER
Mary Ellen Hildreth13 BIRTHPLACE OF MOTHER
(State or country) Mass.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isabel S. Farrington(Address) Chevy Chase School, Md.15 Filed 6-2-1930 Thomas K. Conrad
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
June 1st, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Not attended, in this attackthat I last saw him alive on June 1st, 1930and that death occurred on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH * was as follows:

Acute Dilatation of Heart(Duration) 10 Mins.
yrs. mos. ds.Contributory Arteriosclerosis, Myocarditis.
Secondary(Signed) Thomas K. Conrad M. D.
6-1-30 (Address) Chevy Chase, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, Recent Residents)

At place of death yrs. 17 mos. ds. In the 17 yrs. mos. ds.Where was disease contracted, Very likely.
if not at place of death?Former or usual residence 6410 Con. Ave., Chevy Chase, Md19 PLACE OF BURIAL OR REMOVAL Md.
Fort Lincoln Cemetery, DATE OF BURIAL 6-3-193020 UNDERTAKER Jos. Lawless ADDRESS 1754 Pa. Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Senile," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUN 14 1930
BUREAU V. S.

N.B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>			05695 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Forest Glen</u> , (No. <u>740</u>)			Registration Dist. No. <u>214</u>	
2 FULL NAME <u>Harriet Ellen, Harriet Cutler</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>F</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>married</u> (Write the word)		
6 DATE OF BIRTH <u>June 11, 1850</u> (Month) (Day) (Year)				
7 AGE <u>79</u> yrs. <u>10</u> mos. <u>25</u> ds. or <u>25</u> min. ? If LESS than 1 day....hrs.				
8 OCCUPATION (a) Trade, profession or particular kind of work. <u>housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Home</u>				
9 BIRTHPLACE (State or country) <u>Laysboro, Massachusetts</u>				
PARENTS	10 NAME OF FATHER <u>Cutler, James E.</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>New Brunswick, Can.</u>			
	12 MAIDEN NAME OF MOTHER <u>Hatchorn, Sarah</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Laysboro, Mass.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. M. M. Cutler Stander</u> (Address) <u>Forest Glen</u>				
15 Filed <u>May 5 1930</u> <u>J. E. Wadley</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>MAY 5, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Aug 15, 1929</u> , to <u>May 5, 1930</u> , that I last saw her alive on <u>May 4, 1930</u> , and that death occurred on the date stated above, at <u>5:30 A.M.</u>				
The CAUSE OF DEATH was as follows: <u>Cerebral Hemorrhage</u>				
Contributory <u>Arterio Sclerosis</u> Secondary				
(Duration) <u>2</u> yrs. <u>4</u> mos. <u>20</u> ds.				
(Signed) <u>W. Mitchell</u> M. D. <u>May 5, 1930</u> (Address) <u>Subur. Spring, Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death.... yrs. mos. da. In the State.... yrs. mos. da. Where was disease contracted, if not at place of death?.....				
Former or usual residence.....				
19 PLACE OF BURIAL OR REMOVAL <u>Abbey Mausoleum</u>				DATE OF BURIAL <u>5-7-1930</u>
20 UNDERTAKER <u>W. R. Humphrey Jr</u>				ADDRESS <u>Rockville Md</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scout*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (occupation) 6 yrs.*. For persons who have no occupation, whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrovascular fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "diphtheria"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meningitis* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverberant wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 7 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

05696 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

Village or City Forest Glen (No. 101-a)

St.: _____ Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Dr. Jesse Walter Lewkes

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Nov 14 1850
(Month) (Day) (Year)

7 AGE 79 yrs. 6 mos. 16 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Newton Mass

10 NAME OF FATHER Jesse Lewkes

11 BIRTHPLACE OF FATHER (State or country) Ipswich, Mass

12 MAIDEN NAME OF MOTHER Susan E. Jewitt

13 BIRTHPLACE OF MOTHER (State or Country) Ipswich, Mass

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. H. Hewkes
(Address) 58 Maple St Newton Mass

15 Filed May 31 1930 W. L. Linn
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 31 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 21 1930 to May 30 1930, that I last saw him alive on May 30 1930,

and that death occurred on the date stated above, at 4:30 A. M.
The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage

(Duration) ____ yrs. ____ mos. 10 ds.
Contributory Secondary Solar Pneumonia

(Duration) ____ yrs. ____ mos. 1 ds.
(Signed) Marion Banthead M. D.
May 31 1930 (Address) Silver Spring Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Abbey Mausoleum - Va.
Arlington Co. DATE OF BURIAL June 2, 1930

20 UNDERTAKER W. R. Pamphrey Jr. ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 7 1920

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Kennings (No. _____)

2 FULL NAME Ruby B. Judson Field

10534

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH June 21, 1839
(Month) (Day) (Year)

7 AGE 91 yrs. 2 mos. 13 ds. If LESS than 1 day ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer) _____

8 BIRTHPLACE (State or country) Michigan

10 NAME OF FATHER Alfred Judson

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Louise Bartlett

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. J. Field
(Address) Kennings Md

15 Filed Sep 5 1930 W. L. Deans
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 4, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 25, 1930 to Sept 4, 1930

that I last saw her alive on Sept 4, 1930

and that death occurred on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH * was as follows:

Cerebral Embolism

(Duration) ____ yrs. ____ mos. 13 ds.

Contributory Secondary Cerebral Embolism

(Duration) ____ yrs. ____ mos. 13 ds.

(Signed) W. L. Deans M. D.

Sep 5 1930 (Address) Kennings

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Blue Ridge Ranger DATE OF BURIAL Sep 8, 1930

20 UNDERTAKER W. R. Humphrey ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probable* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 7 1930

BUREAU

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Rockville

(No. _____)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

2/3

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Rebecca Georganna Fields

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)*Widowed*

6 DATE OF BIRTH

*February**2**1830*

(Month)

(Day)

(Year)

7 AGE

*100**8**mos.**6**ds.*If LESS than
1 day ____ hrs.
or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

None

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Charles Beckwith

11 BIRTHPLACE

OF FATHER
(State or country)*Maryland*

12 MAIDEN NAME OF MOTHER

Mary Rabbitt

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Margaret Fields

(Address)

Rockville, Md.

15

Filed *10-9**1930**Mrs. W. T. Pratt*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October

(Month)

8

(Day)

192

1930

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from
July 20 1930 to *October 8* 1930.
that I last saw her alive on *October 8* 1930.and that death occurred on the date stated above, at *5:30 P.m.*
The CAUSE OF DEATH * was as follows:*Old age - no definite disease*

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed)

George E. Palmer M. D.
October 8 1930. (Address) *Rockville, Md.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.

In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*St. Mary's Sem - N. Rockville**Oct 11* 1930

20 UNDERTAKER

ADDRESS

*Wm. Reuben Ramsey**Rockville Md*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "A trophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1930
BUREAU OF VITALS

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Bermantown, Md.2 FULL NAME Thelma Leone Fleet

02124

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)6 DATE OF BIRTH about 1914
(Month) (Day) (Year)7 AGE 16 yrs. 0 mos. 0 ds. If LESS than 1 day ____ hrs. or ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Ernest L. Fleet11 BIRTHPLACE OF FATHER (State or country) Washington, D. C.12 MAIDEN NAME OF MOTHER Martha Neuman13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha Fleet(Address) 1742 You St. N.W., Wash. D.C.15 File March 1 1930 Reed Lee Peterson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2-28-1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 12-29-1929 to 2-28-1930, that I last saw him alive on 2-20-1930,and that death occurred on the date stated above, at 12 noon m.

The CAUSE OF DEATH was as follows:

Epilepsy

Contributory Secondary

(Signed) W. C. M. Kelly M. D.
3-1-1930 (Address) Grithenbury, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brown Cemetery, Bermantown, Md. 3-2, 1930

20 UNDERTAKER

ADDRESS

Warner E. Pumphrey Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1910
BUREAU OF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			03096		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgomery</u>			(100-0)		Registration Dist. No. <u>217</u>	
Village or City <u>Elney Md.</u>			St. <u>Montgomery</u>		Ward <u>Elney</u>	
2 FULL NAME <u>Frederick S. Follenaber</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>3/30/1930</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>July (unknown) 1864</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>3/29/1930</u> to <u>3/30/1930</u> , 1930.			
7 AGE <u>65</u> yrs. <u>9</u> mos. <u>-</u> ds. or <u>-</u> min.?			that I last saw him alive on <u>3/30/1930</u> , 1930.			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Gardener</u> (b) General nature of industry business, or establishment in which employed or (employer)			and that death occurred on the date stated above, at <u>10 a</u> m. The CAUSE OF DEATH * was as follows: <u>Perforating Intestine</u> <u>Injured by Automobile in Brighton</u> <u>Pike near Rockville in</u> (Duration) yrs. mos. ds.			
9 BIRTHPLACE (State or country) <u>N.Y.</u>			Contributory <u>General Peritonitis</u> Secondary (Duration) yrs. mos. ds.			
10 NAME OF FATHER <u>Frederick S. Follenaber</u>			(Signed) <u>W. E. Humphrey</u> M. D. <u>3/30/1930</u> (Address) <u>Sandy Sp.</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>N.Y.</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
12 MAIDEN NAME OF MOTHER <u>Juliette Norman</u>			18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)			
13 BIRTHPLACE OF MOTHER (State or country) <u>N.Y.</u>			At place of death yrs. mos. ds. In the State yrs. mos. ds.			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Microse</u> (Address)			Where was disease contracted, if not at place of death?			
15 Filed <u>Mar 31 1930</u> <u>C. J. Barnsley</u> Registrar			Former or usual residence			
			19 PLACE OF BURIAL OR REMOVAL <u>County Home, Rockville</u>		DATE OF BURIAL <u>Mar 31, 1930</u>	
			20 UNDERTAKER <u>W. E. Humphrey</u>		ADDRESS <u>Rockville, Md.</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

for issued.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 4 1920
BUREAU

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1 PLACE OF DEATH
County Moulgomey

Village or City Barnesville (No. _____)

2 FULL NAME Alice Virginia Ford

01803 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH June 13, 1888
(Month) (Day) (Year)

7 AGE 41 yrs. 8 mos. 28 ds. or min.?
42 If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Isaac Carter

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Wright

13 BIRTHPLACE OF MOTHER (State or Country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Ford
(Address) Barnesville Md

15 Filed Feb 12 1930 M. C. Wilson Registrar
E. White

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 11, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192,
that I last saw him alive on Feb 10, 1930,
and that death occurred on the date stated above, at her home.
The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) T. R. Gough M. D.
Feb 12 1930 (Address) Barnesville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Police Track 171 E. Cemetery Feb 13, 1930

20 UNDERTAKER ADDRESS
W. T. HILTON & SONS BARNESVILLE

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
MAR 5 1930
BUREAU

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1 PLACE OF DEATH County <u>Montgomery</u>		08510 (92)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Silver Spring</u> (No. <u>7907</u> <u>Faulkland Drive</u>)		Ward		Registration Dist. No. <u>214</u>	
2 FULL NAME <u>James Marshall Ford</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>July 30</u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>May 30</u> , 18 <u>57</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>April</u> , 19 <u>26</u> , to <u>July 30</u> , 19 <u>30</u> that I last saw him alive on <u>July 29</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>2:30 a.m.</u> The CAUSE OF DEATH * was as follows: <u>Cerebral Arteriosclerosis</u>		
7 AGE <u>73</u> yrs. <u>2</u> mos. <u>0</u> ds. or min.?			8 OCCUPATION (a) Trade, profession or particular kind of work <u>Roma lunch room</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>room</u>		
9 BIRTHPLACE (State or country) <u>Va.</u>			Contributory Secondary		
10 NAME OF FATHER <u>Charles F. Ford</u>			(Duration) <u>12</u> yrs. — mos. — ds.		
11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u>			(Signed) <u>H. H. J. J. J. J.</u> M. D. <u>July 30</u> , 19 <u>30</u> Address <u>928 Bliss Ave. Silver Spring, Md.</u>		
12 MAIDEN NAME OF MOTHER <u>Rebecca Wright</u>			*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
13 BIRTHPLACE OF MOTHER (State or Country) <u>N.Y.</u>			19 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. James M. Ford</u> (Address) <u>7997 Faulkland Drive Silver Spring, Md.</u>			At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____		
15 Filed <u>July 30</u> , 19 <u>30</u> <u>J. E. Henderson</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Glenwood</u>		
			DATE OF BURIAL <u>Aug. 1</u> , 19 <u>30</u>		
			20 UNDERTAKER <u>The S. H. Hines Co.</u>		
			ADDRESS <u>2901 14th St. Wash., D.C.</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Village or City

2 FULL NAME

09378

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH Unknown 1850 (Month) (Day) (Year)7 AGE 80 yrs. — mos. — ds. If LESS than 1 day — hrs. or — min.?8 OCCUPATION (a) Trade, profession or particular kind of work None (b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Ms10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Forbes (Address) North Md15 Filed Aug 23, 1923 C. S. Arnold Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 22, 1923 (Month) (Day) (Year)17 I HEREBY CERTIFY That I attended the deceased from Aug 1st 1923 to Aug 22 1923that I last saw him alive on Aug 20 1923and that death occurred on the date stated above, at 11:30 a.m.The CAUSE OF DEATH * was as follows: Valvular diseaseof heart(Duration) 6 yrs. 6 mos. 2 ds.Contributor Valvular diseaseSecondary of heart(Duration) 6 yrs. 6 mos. 2 ds.(Signed) Aug 23 1923 (Address) Kenilworth

*State the disease causing death, or, in death from Violent Causes, state (1) Means of injury and (2) Whether

Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL North MdDATE OF BURIAL Aug 24 192320 UNDERTAKER Leo SnoddyADDRESS Forbes

If more blanks are needed, address State Registrar, 13 W. Saratoga St., Balto., requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (c) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite: avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 4 1930

PUBLIC HEALTH

MARGIN RESERVED FOR BINDING

WRITE HERE WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

01804

(160)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 211

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1920

W. E. Ligon

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 10 1920, to Feb 10 1920

that I last saw him alive on Feb 10 1920

and that death occurred on the date stated above, at 10:13 A.M.

The CAUSE OF DEATH * was as follows:

Congenital debility.

(Duration) yrs. mos. ds.

Contributory
Secondary(Signed) Stanley D. Barker M. D.
Feb 10 1920 (Address) Gaithersburg

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) 3 mos 3 mos

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rocky Hill

Feb 11, 1920

20 UNDERTAKER

ADDRESS

E. C. Sartor

Gaithersburg

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

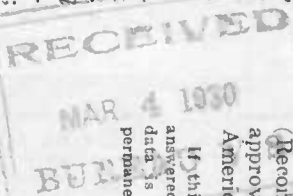
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be completed before the certificate is permanently filed



WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

NOTE--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Laytonville (No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Blauche T. FrazierRegistration Dist. No. 215

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 27, 1930
(Month) (Day) (Year)

7 AGE _____ yrs. 3 mos. 7 ds. or _____ min. If LESS than 1 day _____ hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Baby
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Shaversburg Frazier

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Kenneth Clayton

13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mollie Clayton(Address) Eastonsburg RFD#

15 Filed Nov 5, 1930 V H Dyeon Registrar

STATE OF MARYLAND
CERTIFICATE OF DEATH

13913

(13)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 5, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 25, 1930 to Nov 5, 1930

that I last saw him alive on Nov 3, 1930

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH * was as follows:

Gastro-intestinal

(Duration) _____ yrs. 3 mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) V H Dyeon M. D.
Nov 5, 1930 (Address) Laytonville Ind

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Brook Grove Cem DATE OF BURIAL Nov 5, 1930

20 UNDERTAKER Roy W Barber ADDRESS Eastonsburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

DEC 6 1930
BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Gaithersburg (No. _____)

2 FULL NAME Doris Eugene Frazier

08145 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 278

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Apr. 23, 1930
(Month) (Day) (Year)

7 AGE 2 yrs. 2 mos. 15 ds. If LESS than 1 day _____ hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) D.C.

10 NAME OF FATHER ? (illegitimate)

11 BIRTHPLACE OF FATHER ?
(State or country)

12 MAIDEN NAME OF MOTHER Delia Frazier

13 BIRTHPLACE OF MOTHER _____
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1 mother

(Address) Gaithersburg Md

15 Filed July 9 1930 Trachel Lee Johnson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 8, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from did suddenly 192 _____ to 192 _____

that I last saw him alive on _____, 192 _____

and that death occurred on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH * was as follows:

acute gastro-intestinal

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. J. Brochart M. D.

7-8 1930 (Address) Gaithersburg Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Brook Grove Ind July 9, 1930

20 UNDERTAKER ADDRESS

J. J. Brochart Gaithersburg Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

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MAY 8 1930
BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

*Montgomery*08146 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *218*Village or City *in Frederick* (No. *md*)

St: _____ Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME *William Frazier*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>male</i>	4 COLOR OR RACE <i>Colored</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Widowed</i> (Write the word)
----------------------	-----------------------------------	---

6 DATE OF BIRTH

unknown, unknown 1851
(Month) (Day) (Year)

7 AGE

79 yrs. _____ mos. _____ ds. _____
If LESS than 1 day _____ hrs. _____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work *Farm work*
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE
(State or country)*md*

10 NAME OF FATHER

*Benjamin Frazier*11 BIRTHPLACE OF FATHER
(State or country)*md*

12 MAIDEN NAME OF MOTHER

*Sallie Foreman*13 BIRTHPLACE OF MOTHER
(State or Country)*md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ollie Frazier

(Address)

Eastonburg Rd

15 Filed

July 27 1930 *V. H. Dixon*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 25, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *death immediately without* _____, 192____
that I last saw him alive on *medical attention* _____, 192____and that death occurred on the date stated above, at *About 9 P.M.*
The CAUSE OF DEATH * was as follows:*Myo-Cardiac Insufficiency*Contributory
Secondary*Cardiac Dilatation*
(Duration) _____ yrs. *3* mos. _____ ds.
probably 10 minutes
(Duration) _____ yrs. _____ mos. _____ ds.(Signed) *V. H. Dixon* _____ M. D.
July 26, 1930 (Address) *Laytonsville md*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brook Grove Cem *July 29, 1930*

20 UNDERTAKER

ADDRESS

Ray W Barber *Laytonsville md*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coul mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 6 1906

MARGIN RESERVED FOR BINDING
WRITE HERE WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County MontgomeryVillage or City Cherry Chase (No. 4619-Langdum Lane St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 2162 FULL NAME Viola Olive Fuller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)6 DATE OF BIRTH July 7, 1897
(Month) (Day) (Year)7 AGE 33 yrs. 5 mos. 4 ds. or min. If LESS than 1 day hrs. or min.8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Virginia Fairfax10 NAME OF FATHER Edmund E. Oliver11 BIRTHPLACE OF FATHER (State or country) Virginia12 MAIDEN NAME OF MOTHER Marietta B. Reid13 BIRTHPLACE OF MOTHER (State or Country) Warren County Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank T. Fuller(Address) 4619 Langdum Lane15 Filed June 19, 1930 Ben C. Perry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 18, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from June 15, 1930 to June 17, 1930, that I last saw him alive on June 15, 1930, and that death occurred on the date stated above, at 12¹⁴ a.m.

The CAUSE OF DEATH * was as follows:

Pulmonary TuberculosisContributory Secondary asthenia
(Duration) 6 yrs. — mos. — ds.(Signed) W. H. H. H. H. M. D.
June 18, 1930 (Address) 1629 Columbia Rd

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Charlottesville, Va. DATE OF BURIAL June 18, 193020 UNDERTAKER The S. H. Hines Co. ADDRESS 2901-24th St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUL 5 1918
BUREAU OF
VITAL STATISTICS

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Wg

Village or City Silver Spring (No. 48) Maplewood Jan St. Ward

06830 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Franklin Mathew Gallagher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Sept. 3, 1838
(Month) (Day) (Year)

7 AGE 92 yrs. 3 mos. 0 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION (a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Cent Co. Md.

10 NAME OF FATHER Matthew Gallagher

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Letitia Galt

13 BIRTHPLACE OF MOTHER (State or Country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roman Hawland

(Address) Silver Spring, Md.

15 Filed June 3, 1930 A. B. Dudley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 3, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 1st, 1930 to June 3, 1930

that I last saw him alive on June 2, 1930

and that death occurred on the date stated above, at 6:20 A.M.

The CAUSE OF DEATH * was as follows:

Cancer of side face

(Duration) 4 yrs. 0 mos. 0 ds.

Contributory arteriosclerosis & Hypertension

(Duration) 15 yrs. 0 mos. 0 ds.

(Signed) A. B. Dudley M. D.

June 3, 1930 (Address) Silver Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 6 mos. 17 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? DC.

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Washington DC DATE OF BURIAL 6/3, 1930

20 UNDERTAKER Martin H. Hysong Co ADDRESS 1300 N. 7th St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUL 10 1930
BUREAU V. 8.

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1 PLACE OF DEATH

County MontgomeryVillage or City Cherry Chase, Md.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alphonse m. Gautier

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

7 AGE 46? yrs. _____ mos. _____ ds. or _____ min. IF LESS than 1 day _____ hrs.

OCCUPATION (a) Trade, profession or particular kind of work watchman (b) General nature of industry business, or establishment in which employed or (employer) Cherry Chase swimming pool

9 BIRTHPLACE (State or country) France?

10 NAME OF FATHER _____

11 BIRTHPLACE OF FATHER (State or country) _____

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (State or Country) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) From Police record (Address) at Bethesda, Md.

15 Filed Mar 10 1930 Benj. C. Perry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 26, 1930. (Month) _____ (Day) _____ (Year) _____

17 I HEREBY CERTIFY, That I attended the deceased from death on arrival 192 _____ to 192 _____ that I last saw him alive on 192 _____

and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH was as follows: Revolver wound of head - accidental.

Contributory Secondary

(Signed) E. P. Bauerfeld M.D. (Duration) _____ yrs. _____ mos. _____ ds. 2/27/30 (Address) Bethesda, Md.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's Cemetery - Rockville, Md. March 11, 1930

20 UNDERTAKER

ADDRESS

Warner E. Humphrey Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Coronoma*, *Sarcoma*, etc., or (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 6 1900

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Sandwich</u>			0567 STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Sandwich</u> (No. <u>74a</u>)			Registration Dist. No. <u>214</u>		
2 FULL NAME <u>James F. Garner</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>So</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Widow</u> (Write the word)			
6 DATE OF BIRTH <u>June 18, 1898</u> (Month) (Day) (Year)					
7 AGE <u>82</u> yrs. <u>6</u> mos. <u>12</u> ds. IF LESS than 1 day ___ hrs. or ___ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Ga</u>					
10 NAME OF FATHER <u>Wm F. Giles</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Ga</u>					
12 MAIDEN NAME OF MOTHER <u>Frances Cronan</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ga</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Debbie Collins</u> (Address) <u>Sandwich</u>					
15 Filed <u>Jan 31, 1929</u> <u>W D Seab</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan 30, 1930</u> (Month) (Day) (Year)					
I HEREBY CERTIFY, That I attended the deceased from <u>Jan 29, 1930</u> to <u>Jan 30, 1930</u> , 19 <u>30</u> that I last saw him alive on <u>Jan 29, 1930</u> , 19 <u>30</u> and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH was as follows: <u>Chronic Nephrosis</u> (Duration) <u>2</u> yrs. <u>6</u> mos. <u>12</u> ds.					
Contributory Causes <u>Chronic Nephrosis</u> (Duration) <u>2</u> yrs. <u>6</u> mos. <u>12</u> ds. (Sign) <u>Jan 31, 1930</u> (Address) <u>Washington</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Rock Creek</u>				DATE OF BURIAL <u>Feb 1, 1930</u>	
20 UNDERTAKER <u>Wm E. Smith</u>				ADDRESS <u>Rock Hill</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 7 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

03097

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City

Berkentice Md

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ella S Sartwell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

7-15-1860
(Month) (Day) (Year)

7 AGE

69 yrs. 7 mos. 16 ds. or min.

IF LESS than
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF

FATHER

H. C. Sartwell

11 BIRTHPLACE

OF FATHER

(State or country)

Md

12 MAIDEN NAME

OF MOTHER

Maria Sartwell

13 BIRTHPLACE

OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs J. W. Brown

(Address)

Berkentice Md

15 Filed

Mar 4 1930 C. S. Barnsley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

3-3-1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

2/11/1930 to 3/3/1930

that I last saw him alive on 2/24/1930

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH * was as follows:

Cerebral Arteriosclerosis

Contributory
Secondary

(Duration) 3 yrs. mos. ds.

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

(Signed)

J. W. Brown

M. D.

3/4/1930 (Address) Sandy Spring

State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cremated J. W. Lees Sons March 5, 1930

20 UNDERTAKER

ADDRESS

Roy W. Barber Gaithersburg Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

for issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Sellsman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 4 1890

BUR

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Wt.

Village or City Silver Spring (No. _____)

2 FULL NAME Mrs. Laura Virginia Gater

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH May 6, 1861
(Month) (Day) (Year)

7 AGE 69 yrs. 6 mos. 24 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Wt. Co.

10 NAME OF FATHER Hershire Robertson

11 BIRTHPLACE OF FATHER (State or country) Wt.

12 MAIDEN NAME OF MOTHER Mrs. Gattings

13 BIRTHPLACE OF MOTHER (State or country) Wt.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Gater
(Address) Silver Spring, Wt.

15 Filed Nov. 30, 1930 J. S. Wadley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 30, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 30, 1930 to Nov 30, 1930

that I last saw him alive on Nov 30, 1930, and that death occurred on the date stated above, at 6:45 A. M.
The CAUSE OF DEATH * was as follows:

Heart Dilatation of heart

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary Myocarditis

(Duration) 8 yrs. ____ mos. ____ ds.

(Signed) W. K. Hayman M. D.

Nov 30, 1930 (Address) Silver Spring, Wt.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Coleville DATE OF BURIAL Dec 2, 1930

20 UNDERTAKER W. R. Humphrey ADDRESS Boothville, Wt.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 8 1900
BUREAU V.S.

MARGIN RESERVED FOR BINDING

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery03098 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214Village or City Aspen (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William George Bates

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH <u>May 3 1913</u> (Month) (Day) (Year)
--

7 AGE <u>56</u> yrs. <u>10</u> mos. <u>26</u> ds. or min.?	IF LESS than 1 day ____ hrs. or ____ min.?
---	--

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) <u>Maryland</u>

10 NAME OF FATHER <u>George W. Bates</u>

11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
--

12 MAIDEN NAME OF MOTHER <u>Martha Mulligan</u>
--

13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary M. Bates
(Address) Rockville, Md. R#315 Filed Mar 30 1930 W. T. Jones
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 28 1930
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended the deceased from March 17 1930 to March 28 1930
that I last saw him alive on March 28 1930and that death occurred on the date stated above, at 7 P m.
The CAUSE OF DEATH * was as follows:Cerebral HemorrhageContributory
Secondary Cerebral Hemorrhage
(Duration) ____ yrs. ____ mos. ____ ds.(Signed) E. M. D.
March 29 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

M. E. Church Cemetery, Gay Hill Md. 30, 1930

20 UNDERTAKER

ADDRESS

Warner E. Purphey, Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 7 1930
BUREAU V. D.

MARGIN RESERVED FOR BINDING
WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Mont -

05697

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City

Olney

(No.

Mont Co Gen Hosp

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Martha Garrison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Mar

6 DATE OF BIRTH

Oct 30, 1897

(Month)

(Day)

(Year)

7 AGE

32 yrs. 5 mos. 1 ds. or min.

If LESS than

1 day hrs.

or min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

MD

10 NAME OF

FATHER

Grimes

11 BIRTHPLACE

OF FATHER

MD

12 MAIDEN NAME

OF MOTHER

Rosie Sullivan

13 BIRTHPLACE

OF MOTHER

(State or country)

MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Tom Garrison

(Address)

Gulford MD

15

Filed

May 1, 1930 C. S. Barnsley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 1 - 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Mar 7 - 1930 to May 1 - 1930

that I last saw her alive on Apr 30 - 1930

and that death occurred on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH * was as follows:

Typic adenoma of Thyroid Gland -
(Exophthalmic type)

(Duration) 1 yrs. 3 mos. - ds.

Contributory
Secondary

Myocarditis

(Duration) - yrs. - mos. 54 ds.

(Signed)

Charles Imberson

M. D.

192 (Address) Sandy Spring MD

*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death - yrs. - mos. 54 ds. In the State yrs. - mos. - ds.

Where was disease contracted, home

if not at place of death?

Former or

usual residence

Gulford MD (Howard Co)

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gulford MD

5/3/30

20 UNDERTAKER

ADDRESS

Lloyd Kaiser Laurel MD

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Sexile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Sakoma Park, Md. (No. _____)

2 FULL NAME Leo Beschicketer

01805

(167)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

17 Montg. Ave. St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Dec. 25, 1864
(Month) (Day) (Year)

7 AGE 65 yrs. + mos. 22 ds. or min.? If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Russia

10 NAME OF FATHER M. Beschicketer

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or Country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Charles Beschicketer
(Address) 105 Univ. Park Cal. Md.

15 Filed Feb. 18, 1930 FE. W. W. W. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 17, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on _____, 192

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

Dead on arrival - asphyxiated
illuminating gas (suicide)

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wm. A. Shannon M. D.

Feb. 17, 1930 (Address) 113 - Carroll St. Sakoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Fort Lincoln Cemetery Feb. 18, 1930

20 UNDERTAKER ADDRESS

Warner E. Humphrey Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Cool mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by parabolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 5 1930
BUREAU U. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed or (employee)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

19

Registrar

04453

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Contributory Secondary

(Signed)

M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs. mos. da.

In the State

yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REINTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Toreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection: in respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trachia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL *apoplexia*," "PERIPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH
County Mont

6568

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217Village or City Spencerville No. _____

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Wm Gibson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W - 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Mar
(Write the word)

6 DATE OF BIRTH Aug 12, 1882
(Month) (Day) (Year)

7 AGE 77 yrs. 5 mos. 18 ds. or min.?
If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ms.

10 NAME OF FATHER John A Gibson

11 BIRTHPLACE OF FATHER (State or country) Ms

12 MAIDEN NAME OF MOTHER Ellen Maddox

13 BIRTHPLACE OF MOTHER (State or country) Md -

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) JA Gibson
(Address) Spencerville Ms

15 Filed Jan 31, 1930 C S Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 30 -, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 30 to Jan 30, 1930
that I last saw him alive on Jan 30, 1930

and that death occurred on the date stated above, at 9:57 p. m.
The CAUSE OF DEATH * was as follows:

Chr Myocarditis

(Duration) 10 yrs. - mos. - ds.
Contributory Solar Pneumonia
Secondary

(Duration) - yrs. - mos. 3 ds.
(Signed) C S Barnsley M. D.
Jan 31 - 1930 (Address) Sandy Spring Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death - yrs. - mos. - ds. In the State - yrs. - mos. - ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Burtonsville Ms DATE OF BURIAL Feb 1st, 1930

20 UNDERTAKER Floyd Kaiser ADDRESS Laurel Ms

Reissued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plasterer, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meningitis* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1930

BUR

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Montrose

(No. _____)

2 FULL NAME

Eleanora Harriette Gillies

05698

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *213*

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME, its street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*white*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)*Widow*

6 DATE OF BIRTH

September 29, 1854
(Month) (Day) (Year)

7 AGE

*78 yrs. 8 mos. 27 ds.*If LESS than
1 day ____ hrs.
or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeping

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Edward Richard Picketts

11 BIRTHPLACE OF FATHER

(State or country)

Montgomery Co. Md

12 MAIDEN NAME OF MOTHER

Christie Snail

13 BIRTHPLACE OF MOTHER

(State or Country)

Montgomery Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Myrtle Gillies

(Address)

Rockville, Maryland

15

Filed

5-24 1930 Mrs. W. T. Brett

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 22, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Dec. 1929 to May 21, 1930
that I last saw her alive on *May 21, 1930*and that death occurred on the date stated above, at *10:20 a.m.*

The CAUSE OF DEATH * was as follows:

*Myocarditis*Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

Satural sclerosis(Signed) *A. N. Hartley* M. D.*May 22 1930* (Address) *Rockville*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

U. R. Pumpfroy Jr. 5/25, 1930

20 UNDERTAKER

ADDRESS

Rockville Md. Rockville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 9 1920
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Rockville Md. (No. Chestnut Lodge Sanitarium Ward)2 FULL NAME Reginald GingellSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>
-------------------	---------------------------------	---

6 DATE OF BIRTH Sept 4 1897
(Month) (Day) (Year)7 AGE 38 yrs. 1 mos. 20 ds. or min. ?
If LESS than 1 day.... hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Checking clerk
(b) General nature of industry, business, or establishment in which employed or (employer) Railroad yard9 BIRTHPLACE
(State or country) D.C. Maryland10 NAME OF FATHER George H Gingell11 BIRTHPLACE OF FATHER
(State or country) Maryland12 MAIDEN NAME OF MOTHER Minnie M Suddeth13 BIRTHPLACE OF MOTHER
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dexter M. Bullard(Address) Rockville Md.15 Filed 24 19230 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 24, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Oct 23, 1930, to Oct 24, 1930.that I last saw him alive on Oct 24, 1930.and that death occurred on the date stated above, at 4.25 P.M.

The CAUSE OF DEATH was as follows:

Chronic nephritis, probably, severe
UremiaUnknown (Duration) yrs. mos. ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Dexter M. Bullard M. D.Oct 24, 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. 1 da. In the State, yrs. mos. da.Where was disease contracted, at home
if not at place of death?Former or usual residence Bethesda, Md.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Falls Church Va Oct 27/30

20 UNDERTAKER ADDRESS

G. W. Wise & Co Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered a *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is to be used over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data's essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 5 1930

BURMA

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Takoma (No. _____)2 FULL NAME Aminie F. Godfrey

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH June 24, 1874
(Month) (Day) (Year)

7 AGE 55 yrs. 5 mos. 17 ds. or 1 day hrs. min.?
If LESS than

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Phila. Pa.

10 NAME OF FATHER Carl Able

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertie Able

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. H. Godfrey(Address) 501 Tulip Ave.

15 Filed Feb 11 1930 H. B. Rogers
Registrar

01806

(746)

1 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 11, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 25, 1930 to Feb. 11, 1930
that I last saw her alive on Feb. 10, 1930

and that death occurred on the date stated above, at 5:12 A. m.
The CAUSE OF DEATH * was as follows:

acute endocarditis

Indefinite (Duration) yrs. mos. ds.

Contributory
SecondaryCerebral embolism

(Signed) A. B. Shetty M. D.
Feb. 11, 1930 (Address) 6911 15th St. N.W.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington, D.C. 2/13, 1930

20 UNDERTAKER ADDRESS

H. B. Rogers 924 N. Y. Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *... .shoppneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—carbolic acid*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 4 1930
BUREAU

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

15146
45
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Lakoma Park (No. Washington Sanitarium Hospital St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mr. Max Goldstein

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH November 6 1918
(Month) (Day) (Year)

7 AGE 52 yrs. 28 mos. 28 ds. or min.?
If LESS than 1 day, hrs. min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed or (employer).

9 BIRTHPLACE (State or country)

10 NAME OF FATHER Jonah Goldstein

11 BIRTHPLACE OF FATHER (State or country) Russia

12 MAIDEN NAME OF MOTHER Dora?

13 BIRTHPLACE OF MOTHER (State or country) Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records

(Address) Lakoma Park, Md.

15 Filed Dec 4 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 4, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 19 1930 to Dec 4 1930.

that I last saw him alive on Dec 4 1930.

and that death occurred on the date stated above, at 11:33 a.m.

The CAUSE OF DEATH * was as follows:

Cancer of Colon
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory Secondary

(Duration) 1 yrs. 0 mos. 0 ds.

(Signed) H. E. Rogers M. D.

12/4/30 192 (Address) Lakoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 16 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? Washington D.C.

Former or usual residence Washington D.C. 310 Taylor St. N.W.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wash. D.C. Dec 5, 1930

20 UNDERTAKER ADDRESS

B. Hanzausky 3501-14th St. NW

STATE OF MARYLAND
CERTIFICATE OF DEATH

DATE OF DEATH

PREVIOUS AND BIRTH RECORD

RECEIVED

JAN 3 1931

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

15147

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214Village or City Kensington (No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lucy Amelia Goodwin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH
August 10, 1853
(Month) (Day) (Year)7 AGE
77 yrs. 4 mos. 13 ds. IF LESS than 1 day hrs. or min.?8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country)
Massachusetts10 NAME OF FATHER
John Goodwin11 BIRTHPLACE OF FATHER (State or country)
Massachusetts12 MAIDEN NAME OF MOTHER
Mary Tuttle13 BIRTHPLACE OF MOTHER (State or country)
Massachusetts

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Marie Parker(Address) 23 W. Balto St. Kensington15 Filed Dec 25-1920 W L Lewis
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
December 23, 1920
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from
Oct. 7, 1920 to Dec. 23, 1920that I last saw her alive on Dec. 22, 1920and that death occurred on the date stated above, at 2:15 P. M.

The CAUSE OF DEATH * was as follows:

Lobar pneumonia(Duration) yrs. mos. 5 ds.Contributory Secondary Pulmonary tuberculosis(Signed) Katharine A. Chapman M. D.Dec 23, 1920 (Address) 20 W. Balto., Kensington

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Exhills Union Church 12, 26, 1920

20 UNDERTAKER

ADDRESS

Arner Campbell Exhills, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Chopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931
BUREAU V S

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Lakewood Park (No. 804 Flower Ave)

2 FULL NAME Big Ben. David Stewart Gordon

0569 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH May 23rd, 1882
(Month) (Day) (Year)

7 AGE 97 yrs. 8 mos. 5 ds. or LESS than 1 day ____ hrs. ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Alexander Gordon

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Clark

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss R. L. Powelson
(Address) 804 Flower Ave.

15 Filed Jan 28 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 28th, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 6th, 1928 to January 28th, 1930

that I last saw him alive on January 27th, 1930

and that death occurred on the date stated above, at 9:05 a m.

The CAUSE OF DEATH * was as follows:

Myocarditis.

(Duration) 2 yrs. ____ mos. ____ ds.
Contributory old age
Secondary

(Signed) Rapetta E Kress M. D.
Jan 28th 1930 (Address) 705 Conallan

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 9 mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death

Former or usual residence Walter Reed Hospital

19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL Jan 28th 1930

20 UNDERTAKER Dr. Bauer's Sons Inc ADDRESS 1754 P. Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE, (CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 6 1930
BUREAU V. S.

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

01807

(117)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223Village or City Takoma Park (No. Washington Hospital St. 60 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Harold H. Gough

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE. ☒ MARRIED. ☐ WIDOWED. ☐ OR DIVORCED. (Write the word)6 DATE OF BIRTH April 10, 1901
(Month) (Day) (Year)7 AGE 28 yrs. 10 mos. 29 ds. or LESS than 1 day hrs. min.?8 OCCUPATION
(a) Trade, profession or particular kind of work newspaper salesman
(b) General nature of industry business, or establishment in which employed or (employer) Salesman9 BIRTHPLACE (State or country) Indiana10 NAME OF FATHER E. H. Gough.11 BIRTHPLACE OF FATHER (State or country) Indiana12 MAIDEN NAME OF MOTHER Nellie Hagen.13 BIRTHPLACE OF MOTHER (State or Country) Indiana.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) From Hospital Records
(Address) _____15 Filed Feb 9 1930 192 H. H. Rogers

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 9, 1930
Feb. (Month) 9 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from Jan 30 1930 to Feb 9, 1930, that I last saw him alive on Feb 9, 1930, and that death occurred on the date stated above, at 2:54 A. M. The CAUSE OF DEATH * was as follows:Acute Suppurative Appendicitis(Duration) 11 yrs. 11 mos. 11 ds.Contributory
Secondary(Duration) 9 yrs. 9 mos. 9 ds.(Signed) W. J. Freeman M. D.
Feb. 9 1930 (Address) Takoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 7 yrs. 7 mos. 7 ds. In the State 7 yrs. 7 mos. 7 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 5830 Chevy Chase Parkway Wash.

19 PLACE OF BURIAL OR REMOVAL

Bronville, Ind.

DATE OF BURIAL

Feb. 9, 1930

20 UNDERTAKER

H. B. Lewis

ADDRESS

Art. B. Y. Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (c) *Salesman*, (d) *Grocery*, (e) *Foreman*, (f) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association..)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 4 1930
BUREAU V. D.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Rockville (No. _____)

2 FULL NAME Mary E. Brady

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH July 5, 1872
(Month) (Day) (Year)

7 AGE 57 yrs. 9 mos. 19 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Robert M. Butt

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Ricketts

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George S. Brady
(Address) Rockville, Md.

15 Filed 4-26 1930 Mrs. W. T. Platt
Registrar

04454

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 23rd, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 22, 1930 to April 23, 1930, that I last saw her alive on April 23, 1930

and that death occurred on the date stated above, at 10:15 P. M.
The CAUSE OF DEATH * was as follows:

Chronic myocarditis - 2 yrs.
Terminal bronchopneumonia
2 days
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary Depressive psychosis
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wm. A. Lathrop M. D.
April 24, 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Deerwood M. E. Church Cemetery April 26, 1930

20 UNDERTAKER ADDRESS

Warner E. Humphrey Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphenia," "Anaemia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 8 1900

BUREAU

N. B.--Every item of information should be carefully supplied **ACE** should be stated **EXACTLY**, PHYSICIANS should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

10533

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 228.

Village or City

Takoma Park (No. 31, Garland

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ellie Gray

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 SINGLE, ☒ MARRIED, ☒ WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

Sep 29, 1883, 1 (Month) (Day) (Year)

7 AGE

46 yrs. *11* mos. *14* ds. or min. ? If LESS than 1 day...hrs.

OCCUPATION

(a) Trade, profession or particular kind of work *Actress*(b) General nature of industry business, or establishment in which employed or (employer) *Musician*

9 BIRTHPLACE

(State or country)

Penn

10 NAME OF FATHER

Henry E. Abbott

11 BIRTHPLACE OF FATHER

(State or country)

P. J.

12 MAIDEN NAME OF MOTHER

Mary A. Abbott

13 BIRTHPLACE OF MOTHER

(State or country)

P. J.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Katherine Scott*(Address) *2520-14th St. N.W.*

15

Filed *Sept 13* 1930 *H. E. Rogers*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 13, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Sept. 11 1930, to *Sept. 13*, 1930, that I last saw her alive on *Sept. 12*, 1930, and that death occurred on the date stated above, at *5:30 a.m.*

The CAUSE OF DEATH was as follows:

Syphilis (Cerebral gummatous)

Indefinite (Duration) yrs. mos. da.

Contributory Secondary

(Signed) *A. J. Little* M. D.

Sept. 13 1930 (Address) *6911 S. X. H. W.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... da. In the State, ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Roanoke Va *Sept. 14, 1930*

20 UNDERTAKER ADDRESS

W. W. Chambers *1400 Chapin*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housewife*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. (are should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer—(retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Pneumonia*, *fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"; *Lober pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Triema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

BUREAU V. 8

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Hyattstown No. _____

2 FULL NAME Gray

69379

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 211

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE Leve 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) S

6 DATE OF BIRTH Aug 27, 1930
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 1 ds. or _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER James O. Gray
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Gladys E. Hackley
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James O. Gray
(Address) Hyattstown Md

15 Filed Aug 29, 1930 W. E. Lewis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 28, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 8-27, 1930 to 8-28, 1930, that I last saw him alive on 8-27, 1930 and that death occurred on the date stated above, at 6 p.m.

The CAUSE OF DEATH * was as follows:

Premature birth
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Signed) C. S. Brooks M.D.
8-28-30 (Address) Fredrick Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mount Pleasant

Aug 30, 1930

20 UNDERTAKER

ADDRESS

W. B. Burdette House

Hyattstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *-obor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia, peritonitis,*" etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

04455

(164)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Takoma Park (No. Washington Sanitarium Ward)

Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Martin Graybill

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH June 8, 1842
(Month) (Day) (Year)

7 AGE 88 yrs. 9 mos. 1 ds. or 1 day hrs. min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Marlin

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address)

15 Filed April 1, 1930 26 E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 1, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 13, 1930 to April 1, 1930.

that I last saw him alive on March 31, 1930.

and that death occurred on the date stated above, at 5:05 A. m.

The CAUSE OF DEATH * was as follows:

Senile Dementia

(Duration) 10 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) M. J. Truman M. D.

Apr. 1, 1930 (Address) Takoma Park

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Takoma Park, D.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Winchester, Va

Apr 1, 1930 Removal

20 UNDERTAKER

ADDRESS

H. B. Reeves

Wash. D. C.

RECEIVED

MAY 8 1930

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

10536

74a

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Cherry Chase (No. 6601) Brookville St. Ward (If death occurred in a hospital or institution, give its NAME in full, street and number.)2 FULL NAME Harry Green

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married6 DATE OF BIRTH Sept. 27, 1930
(Month) (Day) (Year)7 AGE 46 yrs. 6 mos. 0 ds. or 0 min. If LESS than 1 day, hrs.8 OCCUPATION (a) Trade, profession or particular kind of work book
(b) General nature of industry, business, or establishment in which employed or (employer) 9 BIRTHPLACE (State or country) South Carolina10 NAME OF FATHER unknown11 BIRTHPLACE OF FATHER (State or country) unknown12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Bradley(Address) 6601 - Brookville Rd. Md.15 Filed 9-27-1930 Thomas K. Conard Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 27, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from saw deceased after death 1922, that I last saw him alive on , 1922,and that death occurred on the date stated above, at m. The CAUSE OF DEATH * was as follows:apoplexyContributory Secondary arteriosclerosis
(Duration) instantaneous yrs. mos. ds.(Signed) Thomas K. Conard M. D.
9-27-1930 (Address) 5904 Conard Ave. Cheltenham

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients & Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wash. D.C. DATE OF BURIAL Sept. 29, 193020 UNDERTAKER John Allen ADDRESS 12th & Fla. Ave. NW

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonæum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosæ; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT 2 1911
BUREAU V

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Montgomery

Village or City Takoma Park (Washington Sanitarium and Hospital Ward)

² FULL NAME Mrs. Mary Greenbaum

04456 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 273

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH June 3, 1869
(Month) (Day) (Year)

7 AGE 60 yrs. 10 mos. 8 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Jacob Weinberg

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington San. + Hosp. Records
(Address) Takoma Park, Md.

15 Filed April 12 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 11, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 7, 1930 to April 11, 1930, that I last saw her alive on April 11, 1930, and that death occurred on the date stated above, at 9:40 p.m. The CAUSE OF DEATH * was as follows:

Myocardial Insufficiency
(Duration) 2 yrs. mos. ds.

Contributory Bronchopneumonia
Secondary (Duration) ____ yrs. mos. ds.

(Signed) Donald E. Davenport M. D.
April 11, 1930 (Address) Washington Park, Md.

*State the 1 is cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. 5 ds. In the State ____ yrs. ____ mos. 5 ds.

Where was disease contracted, if not at place of death?
Former or usual residence 87 Hillside Ave., Souderton, Penna.

19 PLACE OF BURIAL OR REMOVAL Washington DC DATE OF BURIAL Apr. 14, 1930

20 UNDERTAKER Bernard Danzansky ADDRESS 3501-14th St NW

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 1930
BUREAU

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Rockville (No. _____)2 FULL NAME Edward S. Greene

03099

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 243

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME, its street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
-------------------	---------------------------------	---

6 DATE OF BIRTH March 3, 1881
(Month) (Day) (Year)7 AGE 49 yrs. 0 mos. 20 ds. or min.? LESS than
1 day _____ hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Courneur Ship
(b) General nature of industry business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Ind.10 NAME OF FATHER S. A. Greene11 BIRTHPLACE OF FATHER (State or country) Va.12 MAIDEN NAME OF MOTHER Mary A. Stonestreet13 BIRTHPLACE OF MOTHER (State or Country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Barry Greene
(Address) Va. (Brother)15 Filed 3/26 19230 ms. N.T. Prest
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 24, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from March 17, 1930 to March 24, 1930, that I last saw him alive on March 23, 1930, and that death occurred on the date stated above, at 5:56 m. The CAUSE OF DEATH * was as follows:
Pulmonary pneumoniaContributory Secondary Influenza
(Duration) _____ yrs. _____ mos. 7 ds.(Signed) G. V. Hartley M. D.
March 25, 1930 (Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville Union DATE OF BURIAL 3/26, 193020 UNDERTAKER W. R. Pennington for Rockville ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930
BUREAU V. S.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹PLACE OF DEATH
County Montgomery

Village or City Takoma Park

²FULL NAME William Curtis Grey

08147

(49)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 229

(If death occurred in a hospital or institution, give its NAME. Instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) MARRIED

6 DATE OF BIRTH May 8 1867
(Month) (Day) (Year)

7 AGE 63 yrs. 2 mos. 75 ds. or min. 75 If LESS than 1 day, hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Manager
(b) General nature of industry, business, or establishment in which employed or (employer) Printing Co.

9 BIRTHPLACE (State or country) Pa

10 NAME OF FATHER Hamilton Grey

11 BIRTHPLACE OF FATHER (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Virginia Knowlton

13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address)

15 Filed July 15 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 15 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 13 1930 to July 15 1930 that I last saw him alive on July 15 1930 and that death occurred on the date stated above, at 9:10 a.m.

The CAUSE OF DEATH * was as follows:
Cyelo-nephritis, both kidneys, marked hypertrophy
Uremic Coma of bladder & pros-
tate, with obstructions, probably malignant.
History of difficult urination, ten or fif-
teen years; acute obstruction, proba-
Secondary by two weeks, cont. O.
(Duration) yrs. mos. ds.

(Signed) H. E. Rogers M. D.
July 15 1930 (Address) Takoma Park Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Riverdale Md

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hyattsville Md July 18 1930

20 UNDERTAKER H. Gasch Sons ADDRESS 1344 Annapolis Rd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

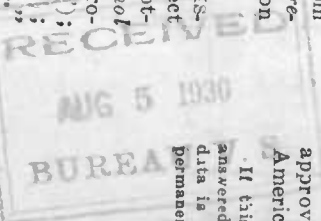
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, "PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

Village or City Brookville (No. _____)

2 FULL NAME Eliza Miller Griffith

01808 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE w 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED mar
(Write the word)

6 DATE OF BIRTH Sept 28, 1851
(Month) (Day) (Year)

7 AGE 79 yrs. 4 mos. 22 ds. IF LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work home
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Mo -

10 NAME OF FATHER Samuel Hopkins

11 BIRTHPLACE OF FATHER (State or country) Mo -

12 MAIDEN NAME OF MOTHER Louisa Day

13 BIRTHPLACE OF MOTHER (State or country) Ind -

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Josiah Sutton
(Address) Brookville, Mo.

15 Filed Feb 21, 1930 C. Barnsley
Registrar

per issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 21st, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 21st, 1930 to Feb 21st, 1930

that I last saw her alive on Feb 21st, 1930

and that death occurred on the date stated above, at 12:45 a.m.

The CAUSE OF DEATH * was as follows:

chr. myocarditis

(Duration) 4 yrs. ____ mos. ____ ds.
Contributory acute dilation of heart
Secondary phr.

(Signed) Charles Thompson M. D.
Feb 21, 1930 (Address) Sandy Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Salem Cem. Brookville DATE OF BURIAL Feb 24, 1930

20 UNDERTAKER W. R. Humphrey ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Muscles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by passing train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAR 6 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day.....hrs.
or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country)10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed 12-12

1930

Mrs. H. T. Pratt

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

October 1929 to Dec. 10, 1930,

that I last saw him alive on Dec. 10, 1930,

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH * was as follows:

Senile arteriosclerosis
& myocarditis

(Duration) 10 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) H. M. Sutherland M. D.

Dec. 11, 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recant Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockville Union Cem.

Dec 12, 1930

20 UNDERTAKER

ADDRESS

Wm. Pruby Humphrey

Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro spinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 6 1931

BUREAU

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1 PLACE OF DEATH
County Montgomery.

Village or City Poolesville (No. _____)

2 FULL NAME Oralter Porter Griggs

05699 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH August 24, 1858
(Month) (Day) (Year)

7 AGE 71 yrs. 9 mos. 5 ds. or _____ min. If LESS than 1 day _____ hrs.

OCCUPATION
(a) Trade, profession or particular kind of work Priest (retired)
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Henry Griggs

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Mathews

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oralter S. Griggs

(Address) Newark, New Jersey

15 Filed May 31 1930 E. W. White
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 29, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from May, 1929 to May 29, 1930, that I last saw him alive on May 27, 1930

and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows:

carcinoma of
stomach

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory cardiac asthma
Secondary _____

(Signed) E. W. White M. D.
May 29 1930 (Address) Poolesville

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Burial DATE OF BURIAL June 1, 1930

20 UNDERTAKER Hellon & Hall ADDRESS Poolesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Travilah (No. _____)

2 FULL NAME Eary Elizabeth Grimes

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Jan 26 1861
(Month) (Day) (Year)

7 AGE 69 yrs. 1 mos. 28 ds. If LESS than 1 day _____ hrs. or _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Thomas Henley
11 BIRTHPLACE OF FATHER Maryland
(State or country)
12 MAIDEN NAME OF MOTHER Cecelia West
13 BIRTHPLACE OF MOTHER Maryland
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ma Owen Grimes
(Address) Rt. 7 P. Rockville Md

15 Filed March 25 1930 Upham D. Bourke Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 25 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 19 1930 to Mar 25 1930, that I last saw her alive on Mar 20 1930, and that death occurred on the date stated above, at 3:30 m.

The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage

(Duration) _____ yrs. 1 mos. 7 ds.

Contributory Secondary Chronic myocarditis
(Duration) 16 yrs. _____ mos. _____ ds.

(Signed) Upham D. Bourke M. D.
Mar 27 1930 (Address) Sausonville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Darnestown DATE OF BURIAL March 27 1930

20 UNDERTAKER Robert Pamphly ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

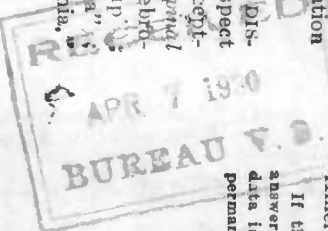
(Approved by U. S. Census and American Public
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Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia," *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A thorough data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Silver Spring (No. 8208 Grove Street)

2 FULL NAME Helen Gould Grimes

08511 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH June 6th 1900
(Month) (Day) (Year)

7 AGE 30 yrs. 1 mos. 23 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Thomas M. Hoyle

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha T. Magruder

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George W. Grimes

(Address) 8208 Grove St. Silver Spring, Md.

15 Filed 7/30 1930 W. E. Dudley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 29 1930
Month (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from October 1927 to July 29 1930
that I last saw her alive on July 29 1930

and that death occurred on the date stated above, at 6:50 P. m.
The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis
(Duration) 4 yrs. ____ mos. ____ ds.

Contributory Tuberculosis of Sarynx
Secondary (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. H. Howlett M. D.
July 29 1930 (Address) 928 E. 30 Ave. Silver Spring, Md.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Int. Dist. Cem. Frederick DATE OF BURIAL July 31 1930

20 UNDERTAKER W. R. Humphrey Jr. ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
SEP 6 1900
RUM

WRITE ONLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery Co.

Village or City

Takoma Park

2 FULL NAME

Baby George Grimm

08148 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

single

6 DATE OF BIRTH

July 23, 1930
Month Day Year

7 AGE

If LESS than
1 day 2 hrs.
yrs. mos. ds. or 50 min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

none

9 BIRTHPLACE
(State or country)

Montgomery Co. Md.

10 NAME OF FATHER

Harold Grimm

11 BIRTHPLACE OF FATHER
(State or country)

Beaver Falls Pa.

12 MAIDEN NAME OF MOTHER

Helma Weissmueller

13 BIRTHPLACE OF MOTHER
(State or country)

Washington D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Harold Grimm

(Address)

318 15th St SE. Wash DC

15 Filed

July 23 1930 H. C. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 23, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 23 (5:20 PM) 1930 to July 23 (8:10 PM) 1930, that I last saw him alive on July 23, 1930, and that death occurred on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH * was as follows:

Cerebral hemorrhage of the new birth

Contributory
Secondary(Signed) Evelyn Buchheim M. D.
July 23 1930 (Address) Wash. San E. Hosp.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Wash DC Washington DC

DATE OF BURIAL

July 24 1930

20 UNDERTAKER

Harry M Padgett 131-11th St. Wash DC

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 5 1930
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Hy

Village or City Silver Spring Md (No. 4)

2 FULL NAME Emma Marie Grosskurth

10537

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

Ward Maplewood (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May 18, 1854
(Month) (Day) (Year)

7 AGE 76 yrs. 3 mos. 29 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work House wife.
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Carl Brandt

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucian Hawland

(Address) Silver Spring Md.

15 Filed Sept. 17, 1930

F. S. Dudeney
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 17, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1st 1930 to Sept 17, 1930, that I last saw him alive on Sept 16, 1930.

and that death occurred on the date stated above, at 5 A. m. The CAUSE OF DEATH * was as follows:

Ruptured cerebral vessel.

(Duration) yrs. mos. 3 ds.

Contributory Secondary Myocarditis

(Duration) 2 yrs. 0 mos. 0 ds.

(Signed) W. R. Hayman M. D.

Sept. 17, 1930 (Address) Silver Spring Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 4 mos. 4 ds. In the State DC yrs. mos. ds.

Where was disease contracted, it not at place of death?

Former or usual residence DC

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash. D.C. Sept 19, 1930

20 UNDERTAKER

ADDRESS

H. M. Padgett

131-11 SE

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer retired 6 yrs*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia",

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 7 1900

PURPA

WRITE PENCIL WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Bellville (No. _____)

2 FULL NAME Margaret E. Grubb

04457

(90)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 2/2

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Dec. 10 1882
(Month) (Day) (Year)

7 AGE 47 yrs. 3 mos. 26 ds. or min. If LESS than 1 day... hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER James Crissey

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Berta Silcott

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lloyd Grubb

(Address) Bellville, Md.

15 Filed 4/7/1930 Mrs. C. H. Hill Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4 6, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 14 1930 to April 6 1930, that I last saw her alive on April 4 1930, and that death occurred on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH was as follows:

Myocarditis
(Cardiac decompensation)

(Duration) 13 yrs. 1 mos. 1 ds.
Contributory Secondary Melanosis

(Signed) Upton D. Houser M. D. 4/7 1930 (Address) Danville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bellville, Md. DATE OF BURIAL 4/8 1930

20 UNDERTAKER Hilton & Hall Beltsville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

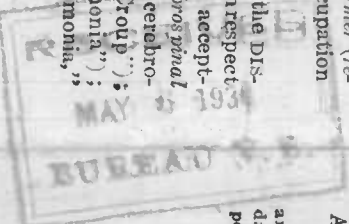
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Painter," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Scarlet fever* (never report "Scarlet Pneumonia"); *Scarlet pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE MAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		6570		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Lakewood Park</u> (No. <u>Wash. San & Hosp.</u>)		St. <u>2</u> Ward <u>223</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Baby Guthrie</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)			
6 DATE OF BIRTH <u>Jan 21st</u> , 1930 (Month) (Day) (Year)					
7 AGE _____ If LESS than 1 day hrs. _____ yrs. _____ mos. _____ ds. or _____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Howard E. Guthrie</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>				
	12 MAIDEN NAME OF MOTHER <u>Hazel C. Osborne</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Wash. D.C.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Howard E. Guthrie</u> (Address) <u>3114 Charming St. N.E.</u>					
15 Filed <u>Jan 22 1930</u> <u>H. E. Rogers</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan 21st</u> , 1930 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 21st</u> , 1930, to <u>Jan 21st</u> , 1930, that I last saw him <u>alive</u> on <u>Jan 21st</u> , 1930, and that death occurred on the date stated above, at <u>6:36</u> p.m. The CAUSE OF DEATH * was as follows: <u>Dry Bitch, and 2x round neck probably suffocation Enuresis.</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary (Signed) <u>Lauretta E. Kress</u> M. D. <u>Jan 21st</u> , 1930. (Address) <u>705 Carrollan</u> State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Cedar Hill</u>				DATE OF BURIAL <u>1/22</u> , 1930	
20 UNDERTAKER <u>H. B. Nevins</u>				ADDRESS <u>924 N. Y. Ave.</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemaia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 6 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Montgomery

Village or City Sandy Spring (No. 74a)

² FULL NAME Anna Hackett

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Jan 12 1860
(Month) (Day) (Year)

7 AGE 70 yrs. 5 mos. 11 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Home work
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wesley Hackett

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elinor unknown

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Hackett

(Address) Sandy Spring

15 Filed June 26 1938 C. S. Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6/23/1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 3/31 1930 to 6/23/1930

that I last saw him alive on 6/12/1930

and that death occurred on the date stated above, at _____, Md.

The CAUSE OF DEATH * was as follows:

General Arterio Sclerosis

(Duration) 3 yrs. mos. ds.

Contributory Cerebral Hemorrhage
Secondary

(Duration) 1 yrs. mos. ds.

(Signed) J. M. Bennett M. D.

6/25/30 (Address) Sandy Spring

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandy Spring June 26, 1938

20 UNDERTAKER ADDRESS

Geo Snowden Rockville Md

for issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Artificer, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired) 6 yrs.* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUL 3 1930
BUREAU OF VITAL STATISTICS

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1 PLACE OF DEATH County <u>Montgomery</u>		01809		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Gaithersburg</u> (No. <u> </u>)		St. <u> </u> Ward <u> </u>		Registration Dist. No. <u>218</u>	
2 FULL NAME <u>Harold B. Haddy</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>male</u>	4 COLOR OR RACE <u>wht.</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Married</u>	6 DATE OF DEATH <u>Feb. 24</u> , 19 <u>30</u> (Month) (Day) (Year)		
6 DATE OF BIRTH <u>Jan. 10</u> , 18 <u>67</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Feb. 24</u> , 19 <u>30</u> , to <u>Feb. 24</u> , 19 <u>30</u> , that I last saw him alive on <u>Feb. 24</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>11 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic myocarditis</u> <u>(sudden dilatation of heart)</u> (Duration) <u>3</u> yrs. <u> </u> mos. <u> </u> ds.		
7 AGE <u>63</u> yrs. <u>1</u> mos. <u>14</u> ds. or <u> </u> min.?			Contributory Secondary		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Physician</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Same</u>			(Signed) <u>Stanley W. Barber</u> M. D. <u>Feb 27</u> , 19 <u>30</u> . (Address) <u>Gaithersburg</u>		
9 BIRTHPLACE (State or country) <u>Pa.</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.		
PARENTS	10 NAME OF FATHER <u>Clinton B. Haddy</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>30</u> yrs. <u> </u> mos. <u> </u> ds. In the <u>30</u> yrs. <u> </u> mos. <u> </u> ds. State <u> </u> yrs. <u> </u> mos. <u> </u> ds.		
	11 BIRTHPLACE OF FATHER (State or country) <u>Pa.</u>		Where was disease contracted, if not at place of death? <u>Same</u>		
	12 MAIDEN NAME OF MOTHER <u>Dorothy Smith</u>		Former or usual residence <u>Same</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Pa.</u>			19 PLACE OF BURIAL OR REMOVAL <u>Beallsville</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. H. B. Haddy</u> (Address) <u>Gaithersburg Md.</u>			DATE OF BURIAL <u>Feb 27</u> , 19 <u>30</u>		
15 Filed <u>Feb 27</u> , 19 <u>30</u> <u>Proctor & Co. Gaithersburg</u> Registrar			20 UNDERTAKER <u>E. C. Sartner</u> ADDRESS <u>Gaithersburg</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bro. chloepneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAR 7 1930
BUREAU VCS.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 6 1930
BUREAU V. S.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

08149

(74a)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Cherry Chase (No. 4 E. Kirk

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sarah E. Hall

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word)6 DATE OF BIRTH July 3-, 1842
(Month) (Day) (Year)7 AGE 88 - 19 mos. 19 ds. or 19 min. ?
If LESS than 1 day....hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Washington, D.C.

PARENTS	10 NAME OF FATHER <u>Henry H. Gunnell</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>Washington, D.C.</u>
	12 MAIDEN NAME OF MOTHER <u>Mary Johnson</u>
	13 BIRTHPLACE OF MOTHER (State or country) <u>Wash. D.C.</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clarence Hall(Address) 4-E. Kirk St. Cherry Chase15 Filed July 22 1930 Benj. C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 22nd, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 1st 1930, to July 22 1930,
that I last saw her alive on July 22 1930,
and that death occurred on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH was as follows:

General debility
Cerebral hemorrhage
(Duration) _____ yrs. _____ mos. 10 ds.Contributory
Secondary(Signed) Benj. C. Perry M.D.
July 22 1930 (Address) Bethesda, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.... yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Arlington Nat. Cem., Va. DATE OF BURIAL July 24, 193020 UNDERTAKER Wm. Lee & Sons ADDRESS Washington, D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railroad train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 5 1930

BUREAU V

Mr. B. B. Perry
Baltimore
Md.

MARGIN RESERVED FOR BINDING

WRITE MAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Montgomery

6572 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

Village or City Rockville (No. Chestnut Lodge Sanitarium Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

² FULL NAME Laura C. Halley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem. 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Mar. 17 1859
(Month) (Day) (Year)

7 AGE 70 yrs. 10 mos. 3 ds. IF LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Missouri

10 NAME OF FATHER Samuel Cragdock

11 BIRTHPLACE OF FATHER (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Mary Wilcox

13 BIRTHPLACE OF MOTHER (State or Country) Missouri

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles R. L. Halley
(Address) Washington D.C.

15 Filed 1-21-1980 Mrs. H. T. Platt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 20 1930
Jan (Month) 20 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 6 1929 to Jan 20 1930, that I last saw her alive on Jan 20 1930

and that death occurred on the date stated above, at 8:05 m.
The CAUSE OF DEATH * was as follows:

Chronic Myocarditis

Unknown (Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Dexter M. Bullard M.D.
Jan 20 1930 (Address) Rockville, Md.

*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 11 mos. 14 ds. In the State 1 yrs. 11 mos. 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Missouri

19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL 1-21-1930

20 UNDERTAKER M.W. Hyatt Co. ADDRESS 1300 N. ST. N.W.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 8 1934
BUREAU

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City near Rockville (No. 2nd)2 FULL NAME Minnie Knoll Hatterman15149 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH October 19, 1907
(Month) (Day) (Year)7 AGE 23 yrs. 2 mos. 11 ds. or 1 day 1 hrs. 1 min.?
If LESS than 1 day8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Walter Hatterman11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Rosa Carter13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Hatterman(Address) Laithersburg15 Filed Jan 1st 1930 V. H. Dixon
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec-30, 1930
Dec (Month) 30 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from 12/27, 1930 to 12/30, 1930, that I last saw her alive on 12/30/30, 1930, and that death occurred on the date stated above, at 3:30 a.m. The CAUSE OF DEATH * was as follows:Acute pneumonic phthisisContributory Secondary (Duration) 6 yrs. 6 mos. 6 ds.
Cardiac asthma(Signed) Chas. R. Smith M. D. 12/30/1930 (Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 6 yrs. 6 mos. 6 ds. In the State 6 yrs. 6 mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Danvers Cemetery Jan 1, 1931

20 UNDERTAKER ADDRESS

Roy W. Barker LaithersburgIf more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1. und

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931

BUREAU

NOTE--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

15150

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218Village or City Laytonville (No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Frederick Hammond

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
----------------------	---------------------------------	---

6 DATE OF BIRTH <u>Oct 26, 1863</u> (Month) (Day) (Year)
--

7 AGE <u>67 yrs. 1 mos. 10 ds.</u>	If LESS than 1 day ____ hrs. or ____ min.?
---------------------------------------	--

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Miner</u> (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) <u>Urbania Md</u>

10 NAME OF FATHER <u>Augustus Hammond</u>
--

11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
--

12 MAIDEN NAME OF MOTHER <u>Mary Virginia Hammond</u>
--

13 BIRTHPLACE OF MOTHER (State or Country) <u>Md</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. M. Hammond(Address) New Market, Md.

15 Filed <u>Dec 8, 1930</u> <u>W. R. Dyson</u> Registrar
--

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>Dec 7, 1930</u> (Month) (Day) (Year)
--

17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 1st, 1929</u> to <u>Dec 7th, 1930</u> that I last saw him alive on <u>Dec 7th, 1930</u>

and that death occurred on the date stated above, at <u>4 P. M.</u> The CAUSE OF DEATH * was as follows:

<u>Angina Pectoris</u>

Contributory Secondary <u>Sclerosis of the Coronary Arteries</u> (Duration) <u>4 hours</u> yrs. mos. ds.
<u>unknown</u> (Duration) yrs. mos. ds.

(Signed) <u>W. R. Dyson</u> M. D. <u>Dec 8, 1930</u> (Address) <u>Laytonville</u>
--

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
--

At place of death yrs. mos. ds.	In the State yrs. mos. ds.
---------------------------------	----------------------------

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL <u>New Market Cemetery</u>	DATE OF BURIAL <u>Dec 10, 1930</u>
---	---------------------------------------

20 UNDERTAKER <u>J. E. Tackett</u>	ADDRESS <u>Gaithersburg</u>
---------------------------------------	--------------------------------

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealt," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemic" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931

BUREAU

MARGIN RESERVED FOR BINDING

WRITE IN WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

8

08150

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

Village or City

Rock Spring

(No. _____)

St. _____

Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Infant of Mary ~~Thompson~~ *Hart*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

single

6 DATE OF BIRTH

July 7th, 1930.
(Month) (Day) (Year)

7 AGE

0 yrs. 0 mos. 0 ds. or min.?

If LESS than
1 day hrs.
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF

FATHER

Mukunom

11 BIRTHPLACE

OF FATHER

(State or country)

Mukunom

12 MAIDEN NAME

OF MOTHER

Mary Harris

13 BIRTHPLACE

OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Emma Jones

(Address)

Bethesda, Md.

15 Filed

7/8

1930

Mrs. H. T. Crall

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 7th, 1930.
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw h alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Stillborn

Contributory
Secondary

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

7/7/30, (Address) Bethesda, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockville Md 7-8-30

20 UNDERTAKER

ADDRESS

Geo. W. Snowden Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Jord

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plowman, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			05700 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgomery</u>			Registration Dist. No. <u>211</u>	
Village or City <u>Burdetta</u> (No. _____)			St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Edwin A. Hariss</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>		
6 DATE OF BIRTH <u>8th 7th 1862</u> (Month) (Day) (Year)				
7 AGE <u>68</u> yrs. <u>9</u> mos. <u>13</u> ds. If LESS than 1 day ____ hrs. or ____ min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Steam Engineer</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Mfg. plant</u>				
9 BIRTHPLACE (State or country) <u>Montg. Md</u>				
10 NAME OF FATHER <u>Nathan Cos. Hariss</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
12 MAIDEN NAME OF MOTHER <u>Elizabeth Hariss</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Annie V. Hariss</u> (Address) <u>Beyds Md (R.F.D.)</u>				
15 Filed <u>May 22 1930</u> <u>Wm. E. Lewis</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>5 20 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>1923</u> to <u>May 5th 1930</u> , that I last saw him alive on <u>May 4th 1930</u> and that death occurred on the date stated above, at <u>5 P. M.</u>				
The CAUSE OF DEATH * was as follows: <u>Carcinoma of face and neck.</u> <u>Epithelioma of ear, primary lesion.</u> <u>Quart. R.</u> (Duration) <u>20</u> yrs. - mos. - ds.				
Contributory Secondary _____ (Duration) ____ yrs. ____ mos. ____ ds.				
(Signed) <u>Upton D. Young</u> M. D. <u>5720</u> 19 <u>30</u> (Address) <u>Darrouville Md</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.				
Where was disease contracted, if not at place of death? _____				
Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Union Cemetery, Rockville Md</u>				DATE OF BURIAL <u>5/22 1930</u>
20 UNDERTAKER <u>Robert Humphrey</u>				ADDRESS <u>Rockville Md</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

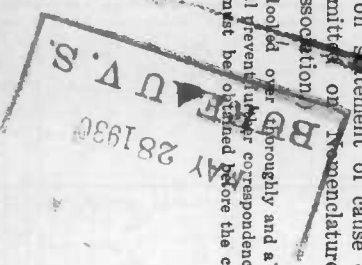
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—Homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Rockville (No. _____)

2 FULL NAME Emma Letticia Harmon

01810

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX J 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH 4 - 19 - 1866
(Month) (Day) (Year)

7 AGE 63 yrs. 9 mos. 18 ds. or min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work H.A.
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Beot.

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Rechele Kuer.

13 BIRTHPLACE OF MOTHER (State or Country) Ms.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Matter Harmon
(Address) Rockville Md.

15 Filed 2-9 1930 Mrs. W.T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2 - 7 - 1930
1/29/30 (Month) (Day) (Year).....

17 I HEREBY CERTIFY, That I attended the deceased from 1/29/1930 to 2/7/1930, that I last saw him alive on 2/7/1930,

and that death occurred on the date stated above, at 11:15 A.M.
The CAUSE OF DEATH * was as follows:

Chronic Interstitial Ne-
phritis
(Duration) 1 yrs. ____ mos. ____ ds.

Contributory Uremia
Secondary

(Duration) ____ yrs. ____ mos. 4 ds.
(Signed) J. W. Bird M. D.
2/7/1930 (Address) Sandy Spring

*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville Union DATE OF BURIAL 2/9, 1930

20 UNDERTAKER W.C. Humphrey Jr. ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

MAR 8 1930
BUREAU V. 3.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County *Harford*

Village or City *Rockville* (No. *1*)

2 FULL NAME *Henry Hartman*

03101 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. *213*

St. *1* Ward *1* (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*
(Write the word)

6 DATE OF BIRTH *1870*
(Month) (Day) (Year)

7 AGE *60* yrs. *5* mos. *1* ds. or *1* day *1* hrs. *1* min. *1* sec.
IF LESS than

8 OCCUPATION
(a) Trade, profession or particular kind of work *Furniture man*
(b) General nature of industry, business, or establishment in which employed or (employer) *Michigan*

9 BIRTHPLACE (State or country) *Michigan*

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (State or country) *Unknown*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (State or Country) *Unknown*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Lizzie Hartman*

(Address) *Rockville Md*

15 Filed *3/17-1920* *ms. 26-7. P. 11*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *March 14*, 19*20*
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from *Dec 11*, 19*19* to *March 14*, 19*20*
that I last saw him alive on *March 14*, 19*20*

and that death occurred on the date stated above at *11* a.m.

The CAUSE OF DEATH was as follows: *State of Phthisis*

State of Phthisis

Contributory *Calculus disease of the heart*

(Duration) *15* yrs. *3* mos. *15* ds.

(Duration) *3* yrs. *3* mos. *15* ds.

(Address) *Rockville Md*

(Signature) *Wm. H. Jones* M. D.

*State the Cause Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death *15* yrs. *3* mos. *15* ds. In the State *15* yrs. *3* mos. *15* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Rockville*

20 UNDERTAKER *Geo. Snowden*

DATE OF BURIAL *March 17*, 19*20*

ADDRESS *Rockville*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

APR 7 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Silver Spring (No. 761 Silver Spring Ave.)2 FULL NAME James Montgomery HarveySTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Widowed

6 DATE OF BIRTH

June 18th, 1851
(Month) (Day) (Year)

7 AGE

79 yrs. 2 mos. 16 ds.
If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed or (employer)

House building

9 BIRTHPLACE

(State or country)

District of Columbia

10 NAME OF FATHER

Thomas Harvey

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Julia Adams

13 BIRTHPLACE OF MOTHER

(State or country)

District of Columbia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Howard Hardesty

(Address)

Silver Spring, Md.

15

Filed Sept 4 1930 J. S. Winkler
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September 3rd, 1930.
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

August 8, 1930 to September 3, 1930
that I last saw him alive on September 3, 1930and that death occurred on the date stated above, at 3:40 P. M.

The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage
(Left hemiplegia)(Duration) — yrs. — mos. 27 ds.Contributory
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) J. J. Howlett M. D.Sept 3, 1930 (Address) 928 Sligo Ave
Silver Spring, Md.

*State the Disease Causing Death, Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds.

In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Grace Church Cemetery 9-6, 1930

20 UNDERTAKER

ADDRESS

Frank Geier's Sons Co. 1113 7 St NW

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer retired—6 yrs.* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

OCT 7 1930

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory," (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		04804 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Gaithersburg</u>		Registration Dist. No. <u>218</u>	
2 FULL NAME <u>Ruth Hosh</u>		St.: _____ Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>X</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)	6 DATE OF DEATH <u>8 apr 1930</u> (Month) (Day) (Year)
6 DATE OF BIRTH <u>apr. 28 1925</u> (Month) (Day) (Year)		17 I HEREBY CERTIFY, That I attended the deceased from <u>7 apr 1930</u> to <u>8 apr. 1930</u> that I last saw him alive on <u>8 apr 1930</u>	
7 AGE <u>4 yrs. 11 mos. 10 ds.</u> If LESS than 1 day ____ hrs. or ____ min.		and that death occurred on the date stated above, at <u>7 a. m.</u> The CAUSE OF DEATH * was as follows: <u>Laryngeal Diphtheria</u> (Duration) ____ yrs. ____ mos. ____ ds.	
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed or (employer)		Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.	
9 BIRTHPLACE (State or country) <u>Va.</u>		(Signed) <u>Stanley W. Zacher</u> M. D. <u>9 apr 1930</u> (Address) <u>Gaithersburg, Md</u>	
10 NAME OF FATHER <u>E. J. Hosh</u>		*State the 1 is also Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>4</u> yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. <u>Same</u>	
12 MAIDEN NAME OF MOTHER <u>Lydia D. Hosh</u>		Where was disease contracted, if not at place of death? <u>Same</u>	
13 BIRTHPLACE OF MOTHER (State or Country) <u>Va.</u>		Former or usual residence <u>Same</u>	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>E. J. Hosh</u> (Address) <u>Gaithersburg, Md</u>			
15 Filed <u>Apr. 10 1930</u> <u>Beulah Dore Elliott</u> Registrar		16 PLACE OF BURIAL OR REMOVAL <u>Gaithersburg Md</u> 20 UNDERTAKER <u>E. C. Yarnum</u> DATE OF BURIAL <u>10 apr 1930</u> ADDRESS <u>Gaithersburg Md</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 7 1930

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

No.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than

1 day — hrs.

or — min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

24 Mar. 1930 to 26 Mar. 1930

that I last saw him alive on 24 Mar. 1930

and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH * was as follows:

Died suddenly.

Probably congenital debility

(Duration) 0 yrs. 0 mos. 2 ds.

Contributory
Secondary

(Signed)

27 Mar. 1930 (Address) Gaithersburg Md.

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 2 ds. In the State Same

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gaithersburg Md. 27 Mar. 1930

20 UNDERTAKER

ADDRESS

E. C. Gartner Gaithersburg Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Ræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1900
BUREAU OF VITAL STATISTICS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Slidell (No. _____)

2 FULL NAME Berj Hutton

08151 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2/2

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Unknown, 1 _____
(Month) (Day) (Year)

7 AGE about 65 yrs. _____ moa. _____ ds. or _____ min.?
If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed or (employer) Fireman

9 BIRTHPLACE (State or country) Va.

10 NAME OF FATHER Berj Hutton Sr.

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) L.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Berj Hutton
(Address) Slidell, Md

15 Filed July 29 1930 by Mrs. C. C. Hillon Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 28, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 28, 1930 to July 28, 1930, that I last saw him alive on July 28, 1930, and that death occurred on the date stated above, at 2 P. m.
The CAUSE OF DEATH * was as follows:

Myocardial Infarction
Endocarditis
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Signed) J. R. Gargal M. D.
July 28, 1930 (Address) Barnesville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Clarksburg DATE OF BURIAL July 31, 1930

20 UNDERTAKER N. J. Hillon & Sons ADDRESS Barnesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

AUG 5 1901

BUREAU OF

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City in Laytonville (No. _____)

2 FULL NAME Sarah M. Hawkins

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Nov 27, 1923
(Month) (Day) (Year)

7 AGE 4 yrs. 7 mos. 14 ds. or LESS than 1 day hrs. min.

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Perrie Hawkins

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Ceyler King

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Perrie Hawkins

(Address) Gaithersburg

15 Filed July 13, 1930 V. H. Dyson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 11, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 7, 1923 to July 11, 1930, that I last saw him alive on July 11, 1930

and that death occurred on the date stated above, at 8 P m. The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. 0 mos. 0 ds.

Contributory Secondary La Grippe

(Duration) 14 mos. 0 ds.

(Signed) V. H. Dyson M. D.

July 13, 1930 (Address) V. H. Dyson

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Brook Grove Cem

DATE OF BURIAL July 13, 1930

20 UNDERTAKER Roy W. Barber

ADDRESS Gaithersburg

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1. md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Imanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹PLACE OF DEATH
County Montgomery

Village or City nr. Laytons ville (No. _____)

²FULL NAME _____

HAWKINS

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED S
(Write the word)

6 DATE OF BIRTH September 20, 1930
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. If LESS than 1 day 0 hrs. or 0 min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work -
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER ZACK HAWKINS

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER MILDRED WILSON

13 BIRTHPLACE OF MOTHER (State or Country) D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mildred Hawkins

(Address) Laytons ville Md

15 Filed Oct. 28 19230 Mrs. W. T. Piatt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 20, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw h alive on 192

and that death occurred on the date stated above, at 6 PM m.

The CAUSE OF DEATH * was as follows:

Stillborn

Contributory Secondary (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) O. E. Hawkins M. D.
Rockville, Md.
192 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL M. Laytons ville DATE OF BURIAL Sept. 20, 1930

20 UNDERTAKER J. E. Hawkins ADDRESS Laytons ville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

COPY SENT TO LOCAL REGISTRAR No. 213 DATE 10/27/30

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a question answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
NOV 5 1930
BUREAU OF VITALS
U. S. DEPT. OF COMMERCE
DIVISION OF VITAL STATISTICS
WASHINGTON, D. C.

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Sycamore Island, Md. (No. 31)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME May M. Healy

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED, Single

WIDOWED

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

Feb. 221904

(Month)

(Day)

(Year)

7 AGE

26315

If LESS than

1 day....hrs.

.....yrs.....mos.....ds. or....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Ireland

10 NAME OF FATHER

Daniel Healy

11 BIRTHPLACE OF FATHER

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Hannah Shea

13 BIRTHPLACE OF MOTHER

(State or country)

Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Margaret M. Healy(Address) 4707-39 St. Rock Island, Md.

15

Filed June 7 1923 Benj. C. Perry

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 71930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

June 5 1930to June 7 1930that I last saw her alive on June 5 1930and that death occurred on the date stated above, at 3:10 A.m.

The CAUSE OF DEATH was as follows:

Pulmonary tuberculosisContributory
SecondaryUnknown

(Duration) yrs. mos. ds.

Lobar pneumonia

(Duration) yrs. mos. ds.

(Signed)

Gregg C. Birdsall M.D.June 7 1930 (Address) 1832 Holzman Road, Wash. D.C.

*State the Disease Causing Death, and whether Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs. mos. ds.

In the

State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

Wash. D.C.June 7 1930

20 UNDERTAKER

W.P.W. Seal

ADDRESS

816-H St. N.E. Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Freeman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 40 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverberant wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is to be used over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Cherry Chase

(No. 4

15 West Buddy Lane

Ward)

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Violet Beale Heap.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed.

DATE OF BIRTH

July

7th

1862

(Month)

(Day)

(Year)

7 AGE

67

yrs.

8

mos.

28

ds.

If LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife.

(b) General nature of industry business, or establishment in which employed or (employer)

None.

9 BIRTHPLACE

(State or country)

Maryland -

10 NAME OF FATHER

Geo N Beale -

11 BIRTHPLACE OF FATHER

(State or country)

Maryland -

12 MAIDEN NAME OF MOTHER

Elizabeth B Wheeler

13 BIRTHPLACE OF MOTHER

(State or country)

North Carolina.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

James F Davidson

(Address)

203 Elm C C Md.

15

Filed

Apr 7

1923

Benj. C. Perry

Registrar

04458

(74-2)

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

4-5

(Month)

5

(Day)

1930

17

I HEREBY CERTIFY, That I attended the deceased from

4-4-30

192

to

4-5-30

192

that I last saw her alive on 4-5-30, 192

and that death occurred on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage.

(Duration)

yrs.

mos.

1

ds.

Contributory
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

James F Davidson

M. D.

4-5

1930 (Address)

203 Elm C C Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Arlington Nat

4-7

1930

20 UNDERTAKER

ADDRESS

Jos. Gawlers Sons

1754 Pa Ave NW

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Typhoid pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 5 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		05701 100-a		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Sellman</u> (No. _____)		St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Laurence Hebron Jr.</u>		Registration Dist. No. <u>212</u>			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Nov. 24, 1929</u> (Month) (Day) (Year)					
7 AGE <u>5</u> yrs. <u>2</u> mos. <u>21</u> ds. or <u>LESS</u> than 1 day <u>hrs.</u> min.?					
OCCUPATION (a) Trade, profession or particular kind of work _____ (b) General nature of industry business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Maryland.</u>					
PARENTS	10 NAME OF FATHER <u>Laurence Hebron</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland.</u>				
	12 MAIDEN NAME OF MOTHER <u>Ada Johnson</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Nettie Johnson</u> (Address) <u>Sellman, Md.</u>					
15 Filed <u>May 16 1930</u> <u>E. W. White</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 15, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw him alive on <u>192</u> , and that death occurred on the date stated above, at <u>1:30 p.m.</u>					
The CAUSE OF DEATH * was as follows: <u>Tuberculosis (No Physician in attendance)</u> <u>Cause of death was apparently</u> <u>pneumonia (Bunch)</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary _____					
(Signed) <u>Johnston</u> M. D. <u>May 16 1930</u> (Address) <u>Dunsmuir Rd</u>					
State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.					
Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Sugarland,</u>				DATE OF BURIAL <u>5/16, 1930</u>	
20 UNDERTAKER <u>W. J. Hilton House</u>				ADDRESS <u>Barnesville Md.</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Rockville (No. _____)

2 FULL NAME William Franklin Hedges

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

(If death occurred in a hospital or institution, give its NAME, stand of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH ? ? 1875
(Month) (Day) (Year)

7 AGE 55 yrs. ? mos. ? ds. or LESS than 1 day ____ hrs. ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Penn.

10 NAME OF FATHER Wm. F. Hedges

11 BIRTHPLACE OF FATHER (State or country) Penn.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Labe Seer (daughter)
(Address) Rockville Md.

15 Filed July 10 1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 13, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 6 1930 to July 13, 1930, that I last saw him on July 13, 1930, and that death occurred on the date stated above, at 4:35 P. m.

The CAUSE OF DEATH * was as follows:

Probably cerebral hemorrhage

(Duration) few minutes
Contributory Without structure with chronic coronary retention + hypertension
(Duration) 5 yrs. 0 mos. 0 ds.
(Signed) Wm. A. Smith M. D.
July 13 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rockville Union Cem. DATE OF BURIAL July 15, 1930

20 UNDERTAKER W. P. Humphrey Jr ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 1930

BUREAU

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. **AGE** should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. **Exact statement of OCCUPATION** is very important. See instructions on back of certificate.

V. S. No. 1.

1 PLACE OF DEATH
County Montgomery
Village or City Edmon (No. 31)

04459 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

2 FULL NAME Miss Dorothy Heil

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH May 12, 1909
(Month) (Day) (Year)

7 AGE 20 yrs. 11 mos. 18 ds. or min. ?
If LESS than 1 day....hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Balto. Ind.

PARENTS
10 NAME OF FATHER Frank Heil
11 BIRTHPLACE OF FATHER (State or country) Balto. Ind.
12 MAIDEN NAME OF MOTHER Clara Edler
13 BIRTHPLACE OF MOTHER (State or country) Balto. Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hubert Heil
(Address) Edmon Ind.

15 Filed Apr 30 1930 C. L. Searle
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 30, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 4/27/1930 to 4/30/1930
that I last saw her alive on 4/27/1930
and that death occurred on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

Contributory Secondary Broncho-Pneumonia

(Duration) yrs. mos. ds.

(Signed) J. M. Heil M.D.

4/30/1930 (Address) Sandy Spring Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Baltimore Ind. May 3rd 1930

BY UNDERTAKER George L. Schmar ADDRESS 2101 Park Ave

Balto. Ind.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinter*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury taken. For violent deaths state means of injury taken. For violent deaths state means of injury taken and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
MAY 6 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day ____ hrs. 1 day ____ yrs. ____ mos. ____ ds. or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1923

W. L. Lane Registrar

06833

(89)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from 1923 to 1923 that I last saw him alive on 1923

and that death occurred on the date stated above, at 12:30 m. The CAUSE OF DEATH was as follows:

Contributory Secondary

(Signed)

1923

(Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.

In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or last residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 10 1930
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

10539 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Olney (No. Mont Co Gen Hosp) St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Edward Cahill Henderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Mar
(Write the word)

6 DATE OF BIRTH Aug 24th 1950
(Month) (Day) (Year)

7 AGE 80 yrs. 0 mos. 27 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired farmer
(b) General nature of industry business, or establishment in which employed or (employer) farming

9 BIRTHPLACE (State or country) Md -

10 NAME OF FATHER John W. Henderson

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (State or country) Md -

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Walter Cashell

(Address) Olney, Md -

15 Filed Sept 22 1953 CLS
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 20th 1950
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 8th 1950 to Sept 20th 1950

that I last saw him alive on Sept 20th 1950

and that death occurred on the date stated above, at 6:40 P.m.
The CAUSE OF DEATH * was as follows:

Chronic Interstitial Nephritis

(Duration) 30 yrs. mos. ds.

Contributory
Secondary

Uremia

(Duration) yrs. mos. 8 ds.

(Signed) Chas. C. Simbleton M. D.

Sept 20 1950 (Address) Sandy Spring Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. 11 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Olney

Former or usual residence Olney

19 PLACE OF BURIAL OR REMOVAL St Marys Em. Rockville Md DATE OF BURIAL Sept. 23, 1950

20 UNDERTAKER Reuben Humphrey ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired) 6 yrs.* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH, the primary affection with respect to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Assthena," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Seizure," "Shock," "Inanition," "Marasmus," "Old Age," "Stroke," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 4 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery01811 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Cherry Chase Terrace Md 6410 Norwood Dr. St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME James A Hendley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH Sept. 16 1873
(Month) (Day) (Year)7 AGE 56 yrs. 4 mos. 26 ds. or min. ? If LESS than 1 day ____ hrs.8 OCCUPATION (a) Trade, profession or particular kind of work clerk
(b) General nature of industry business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Washington D.C.10 NAME OF FATHER James D Hendley11 BIRTHPLACE OF FATHER (State or country) Washington D.C.12 MAIDEN NAME OF MOTHER Josephine Carlstocker13 BIRTHPLACE OF MOTHER (State or country) Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Adah Frances Hendley(Address) 6410 Norwood Drive15 Filed Feb 13 1930 Benj. C. Perry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 12 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Feb. 12th 1930 to Feb. 12th 1930, that I last saw him alive on Feb. 12th 1930, and that death occurred on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH * was as follows:

Angina Pectoris

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary(Signed) Wheeler W. Hulse M. D.
Feb. 12 1930 (Address) Bethesda Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Washington D.C.

DATE OF BURIAL

2/14/1930

20 UNDERTAKER

V. E. Spear & Co

ADDRESS

1009 4th St NW

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

2 If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

MAR 4 1930

BUREAU

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated ACTUALLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Lakewood (No. Baroque Ave St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Julia May Hilckman

06834

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May 4 1874
(Month) (Day) (Year)

7 AGE 56 yrs. 1 mos. 3 ds. or min.?
If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer).

9 BIRTHPLACE (State or country) Jamesstown New York

10 NAME OF FATHER James O'Connell

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Glason

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alberta E. Hilckman

(Address) Baroque Ave.

15 Filed June 7 1920 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 7 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 7 1920 to June 7 1920, that I last saw him alive on June 6/7 1920, and that death occurred on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH * was as follows:

Hypertensive Cardiovascular Disease
Indefinite (Duration) yrs. mos. ds.
Contributory Myocardial Failure
Secondary Sudden (Duration) yrs. mos. ds.
(Signed) Chas. H. Stolshor M. D.
6/7 1920 (Address) Lakewood Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Washington DC DATE OF BURIAL 6/7 1920

20 UNDERTAKER H. B. Hewins ADDRESS 944 N. Y. Ave. N.W.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, "Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. S.

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mtgomery

Village or City Darnestown (No. _____)

2 FULL NAME Unnamed Infant Hilderbrand

04460

(162)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) —

6 DATE OF BIRTH April 25 1930
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. or — min.?
If LESS than 1 day, 3 hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Jan. Henry Hilderbrand

11 BIRTHPLACE OF FATHER (State or country) Fredrick Co Md

12 MAIDEN NAME OF MOTHER Virginia Largentell

13 BIRTHPLACE OF MOTHER (State or country) Fredrick Co Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Hilderbrand

(Address) R. E. W. Germantown

15 Filed 4/25 1930 Dr. D. House Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 25 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from at birth 192 April 25 1930

that I last saw him alive on April 25 1930

and that death occurred on the date stated above, at 9-30 m.

The CAUSE OF DEATH * was as follows:

Cyanosis neonatorum

(Duration) 2 hrs yrs. — mos. — ds.

Contributory
Secondary

(Duration) yrs. — mos. — ds.

(Signed) Dr. D. House M. D.
April 25 1930 (Address) Darnestown, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Darnestown Presby Church DATE OF BURIAL April 26 1930

20 UNDERTAKER Ernest Garber ADDRESS Gaithersburg, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

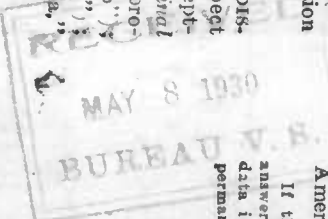
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

68154

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 212

Village or City Bethesda (No. 1)

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Rebecca Aubrey Hill

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Unknown 1 (Month) (Day) (Year)

7 AGE about 80 yrs. mos. ds. or min. If LESS than 1 day hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work From Sales (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Dooly

(Address) Bethesda

15 Filed July 14, 1930 E. W. White Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 13, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1922 to July, 1930.

that I last saw him alive on July 3, 192.

and that death occurred on the date stated above, at 4 P m.

The CAUSE OF DEATH * was as follows:

Cerebral heart disease

(Duration) 10 yrs. mos. ds.

Contributory arterio sclerosis Secondary

(Duration) 20 yrs. mos. ds.

(Signed) E. W. White M. D.

July 14, 1930 (Address) Bethesda

State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Mt Zion DATE OF BURIAL July 15, 1930

20 UNDERTAKER

Wm T H. Clark ADDRESS Bethesda

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>			10540 (1098)			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Elkridge</u> (No. _____)			St. _____ Ward _____			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>Sandra Hiee</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>2</u>	4 COLOR OR RACE <u>Core</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)						
6 DATE OF BIRTH <u>4 - 30 - 1903</u> (Month) (Day) (Year)								
7 AGE <u>27</u> yrs. <u>4</u> mos. <u>20</u> ds. or min.?								
8 OCCUPATION (a) Trade, profession or particular kind of work <u>House maid</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____								
9 BIRTHPLACE (State or country) <u>md</u>								
PARENTS	10 NAME OF FATHER <u>William Hiee</u>							
	11 BIRTHPLACE OF FATHER (State or country) <u>md</u>							
	12 MAIDEN NAME OF MOTHER <u>Anna Carter</u>							
	13 BIRTHPLACE OF MOTHER (State or country) <u>md</u>							
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William Hiee</u> (Address) <u>401 N. M</u>								
15 Filed <u>Sept 21 1930</u> <u>C. Barnaby</u> Registrar								
If more blanks are needed, address State Registrar, 16 W. Seneca St., Balto., Requesting V. S. No. 1.								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>9 / 20 / 1930</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from <u>9 / 16 / 1930</u> to <u>9 / 20 / 1930</u> , that I last saw him alive on <u>9 / 20 / 1930</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>acute myocarditis</u> <u>was preceded rather than</u> <u>for</u> <u>inspiration</u> (Duration) _____ yrs. _____ mos. <u>15</u> ds. Contributory <u>acute bleeding heart</u> Secondary _____ (Duration) _____ yrs. _____ mos. <u>1</u> ds. (Signed) <u>J. M. B.</u> M. D. <u>9 / 22 / 1930</u> (Address) <u>Sandy Spring</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents). At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____								
19 PLACE OF BURIAL OR REMOVAL <u>Sandy Spring</u>						DATE OF BURIAL <u>Sept 21, 1930</u>		
20 UNDERTAKER <u>Geo P. Snowden</u>						ADDRESS <u>Rockville</u>		

for issuance

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

RECEIVED

OCT 4 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by hydrocyanic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING
WRITE IN WITH UNFADING INK--THIS IS A PERMANENT RECORD

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Francis Marion Nimrod

STATE OF MARYLAND
06835 CERTIFICATE OF DEATH
Registration Dist. No. 216

1 PLACE OF DEATH
County Montgomery

Village or City Cherry Chase (No. 5806 Cedar Parkway St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Marion Francis Nimrod (Mrs. Samuel)

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>7</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>	16 DATE OF DEATH <u>June 15</u> , 19 <u>30</u> <u>June</u> (Month) <u>15</u> (Day) <u>1930</u> (Year)	
6 DATE OF BIRTH <u>Nov</u> , <u>10</u> , 18 <u>50</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov 1</u> , 192 <u>9</u> , to <u>June 15</u> , 19 <u>30</u> , that I last saw her alive on <u>June 15</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>2:05 p.m.</u> The CAUSE OF DEATH * was as follows: <u>(1) Chronic valvular heart disease</u> <u>(2) Chronic myocarditis</u>	
7 AGE <u>79</u> yrs. <u>7</u> mos. <u>5</u> ds. or min.?			(Duration) <u>?</u> yrs. <u>?</u> mos. <u>?</u> ds.	
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer)			Contributory Secondary (Duration) <u>?</u> yrs. <u>?</u> mos. <u>?</u> ds.	
9 BIRTHPLACE (State or country) <u>Munday, New York</u>			(Signed) <u>John A. Ryan</u> M. D. <u>June 15</u> , 19 <u>30</u> (Address) <u>5437 Cornsboro</u>	
PARENTS	10 NAME OF FATHER <u>Isaac Bhandor Ball</u>		*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
	11 BIRTHPLACE OF FATHER (State or country) <u>New York State</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>?</u> yrs. <u>?</u> mos. <u>?</u> ds. In the State <u>?</u> yrs. <u>?</u> mos. <u>?</u> ds.	
	12 MAIDEN NAME OF MOTHER <u>Nancy Maria Bryant</u>		Where was disease contracted, if not at place of death? Former or usual residence	
13 BIRTHPLACE OF MOTHER (State or country) <u>New York State</u>		19 PLACE OF BURIAL OR REMOVAL <u>Seawenworth, Kansas</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Alexander Kylic</u> (Address) <u>5806 Cedar Parkway</u> <u>Cherry Chase Md.</u>			DATE OF BURIAL <u>June 18</u> , 19 <u>30</u>	
15 Filed <u>June 17</u> , 192 <u>30</u> <u>Benny C. Perry</u> Registrar			20 UNDERTAKER <u>The S. H. Hines Co.</u> <u>2901-14th St. N. W.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecases; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecases* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUL 5 1930
BUREAU

WRITING PLAIN, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

04461

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

Village or City

Bethesda (No. 6826 Wis. Ave. St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Leon Hinton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE

MARRIED

OR DIVORCED

(Write the word)

(Annoyed)

6 DATE OF BIRTH

April 1st 1930

7 AGE

about 37 yrs. — mos. — ds.

If LESS than

1 day, — hrs.

OR — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

First name Hinton

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Robert Wilson

(Address)

6826 Wis. Ave.

15

Filed

Apr. 8, 1930

Benj. C. Perry

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 7th, 1930

17 I HEREBY CERTIFY, That I attended deceased from

April 2-30, 1930, to April 7th, 1930,that I last saw him alive on April 7th, 1930,

and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Influenza

Contributory

Secondary

(Signed)

Wheeler O. Huff

Apr. 7, 1930 (Address) Bethesda, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, State (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Bradenton Florida

20 UNDERTAKER

W. R. Humphrey Jr

ADDRESS

Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renovar wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

MAY 5 1920

BUREAU OF

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1 PLACE OF DEATH
County Montgomery

Village or City Bethesda (No. 200-Norfolk Ave St. Ward)

2 FULL NAME Upton Bernard Hopkins

09380

(107-C)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Nov 4, 1898
(Month) (Day) (Year)

7 AGE 32 yrs. 9 mos. 4 ds. or min.?
If LESS than 1 day hrs. min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER S. S. Hopkins

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Robbins

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. S. Hopkins

(Address) Bethesda Md

15 Filed Aug 9th 1930 Benj. C. Perry.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 8, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 27, 1930 to Aug 8, 1930

that I last saw him alive on July 8, 1930

and that death occurred on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH * was as follows:

Generalized diphtheria

(Duration) yrs. mos. 10 ds.

Contributors Multiple Military Abscesses
Secondary and

(Duration) yrs. mos. 3 ds.

(Signed) W. R. Humphrey Jr. M. D.

Aug 9, 1930 (Address) 1635 Wisconsin Ave. N.W. Washington

*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockville Union Cemetery Aug 10, 1930

20 UNDERTAKER W. R. Humphrey Jr. ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 3 1930

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V. S. No. 1.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Takoma Park 6621 Eastern Ave. St. Ward

05702

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary E. Hitchcock

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)

Widowed

6 DATE OF BIRTH

June - 17, 1834
(Month) (Day) (Year)

7 AGE

95 yrs. 10 mos. 4 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

New York State

PARENTS

10 NAME OF FATHER

Harry Benham

11 BIRTHPLACE OF FATHER

(State or country)

N.Y. State

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. A. Gower

(Address)

1754 Pa. Ave. N.W.

15

Filed

May 21, 1930

H. C. Rogers

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 21, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Apr. 20, 1930, to May 21, 1930
that I last saw him alive on May 21, 1930

and that death occurred on the date stated above, at 10:35 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(Duration) yrs. mos. ds.

Contributory
Secondary

Enteritis

(Duration) yrs. mos. ds.

(Signed)

J. M. Koebe

M. D.

May 21, 1930 (Address) 1309 Rhode Island Ave. N.E.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL
Arlington, Va. 5-23, 1930

20 UNDERTAKER

J. S. Gardner, Wash. D.C.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

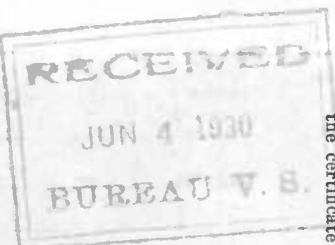
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Truck engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not finally employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

V. S. No. 1

WRITE MAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Mortg. Co.

Village or City

Cherry Chase

(No. 32)

05703

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 716

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Christine G. Hochheim

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

Sept 24, 1870
(Month) (Day) (Year)

7 AGE

59 yrs. 7 mos. 14 ds. or min.?

If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Cambridge Mass

10 NAME OF FATHER

Augusta W. Fox

11 BIRTHPLACE OF FATHER

(State or country)

France

12 MAIDEN NAME OF MOTHER

Augusta Keene Luther

13 BIRTHPLACE OF MOTHER

(State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Augusta Keene

(Address)

32 Underwood St

15 Filed

5-8-1930 Thomas K. Lopez

Registra

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 8, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from Feb. 11, 1930, to May 8, 1930

that I last saw her alive on May 8, 1930

and that death occurred on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH * was as follows:

Coronary-vascular renal
insufficiency. Gen. arteriosclerosis
Hypertension

(Duration) 5 yrs. 5 mos. 8 ds.

Contributory
Secondary

Cerebral Hemorrhage

(Duration) yrs. 5 mos. 8 ds.

(Signed)

Sidney H. Boyars M. D.
May 7, 1930 (Address) 3921 Longman St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D.C. May 8, 1930

20 UNDERTAKER

ADDRESS

Martin W. Hyzong 1300 N. St. N.W.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

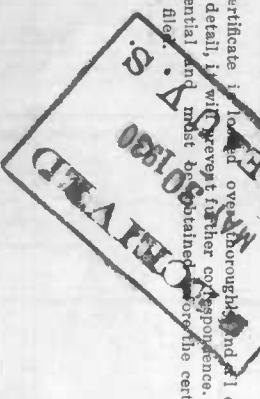
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.; Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is found overabundant, and all questions answered in detail, it will require no further correspondence. All the data is essential and must be contained on the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. **ACE** should be stated. **ACTIVELY PHYSICIANS** should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Takoma Park (No. _____)2 FULL NAME Mrs Alice C. Holden

05704

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH April 13 1847
(Month) (Day) (Year)

7 AGE 83 yrs. 1 mos. 5 ds. or min. ?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Hopkins

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ochworth

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington Sanitarium(Address) Takoma Park, Md.

15 Filed May 17 1930 J. E. Wadley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 17 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from May 9 1930 to May 17 1930 that I last saw him alive on May 17 1930 and that death occurred on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH * was as follows:
Arterial degeneration and arteriosclerosis several years.
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary Cardiac asthma
(Duration) 3 yrs. ____ mos. ____ ds.

(Signed) H. P. Parker M. D.
May 17 1930 (Address) Takoma Park

*State the Disease Causing Death, or, in deaths from Volent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. 9 ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Wash. D.C. DATE OF BURIAL 5-7 1930

20 UNDERTAKER For Fowler's Sons ADDRESS 1734 R Ave N.W.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *House-keeper*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 7 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgomery</u>			Registration Dist. No. <u>223</u>	
Village or City <u>Takoma Park</u> (No. <u>Washington Sawd Hosp.</u>)			St. <u>Washington Sawd Hosp.</u> Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Baby Hallidge</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)		
6 DATE OF BIRTH <u>Dec. 5, 1930</u> (Month) (Day) (Year)				
7 AGE <u>Stillborn</u> If LESS than 1 day ____ hrs. ____ yrs. ____ mos. ____ ds. or ____ min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed or (employer)				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
PARENTS	10 NAME OF FATHER <u>Mr John Hallidge</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Washington, D. C.</u>			
	12 MAIDEN NAME OF MOTHER <u>Agnes Schrein</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Washington, D. C.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mabel B. Estell</u> (Address) <u>Washington, D. C.</u>				
15 Filed <u>Dec 6, 1930</u> <u>W. E. Rogers</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>December 5, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec. 5, 1930</u> to <u>Dec. 5, 1930</u> , that I last saw her alive on <u>Dec 5, 1930</u> , and that death occurred on the date stated above, at <u>6:11 A. M.</u> The CAUSE OF DEATH * was as follows: <u>Intra-uterine asphyxia</u>				
(Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.				
Contributory Secondary (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.				
(Signed) <u>W. E. Rogers</u> M. D. <u>12-6-1930</u> (Address) <u>Takoma Park, Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds.				
Where was disease contracted, if not at place of death? <u>0</u>				
Former or usual residence <u>0</u>				
19 PLACE OF BURIAL OR REMOVAL <u>Disposed of by Sanitarium</u>				DATE OF BURIAL <u>Dec 6, 1930</u>
20 UNDERTAKER				ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Formerly retired 6 yrs.* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiothoracic fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU U. S.

JAN 3 1931

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Cherry Chase Md. 4400 E. Elm (No. 74-a)

06836 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

2 FULL NAME William Stanley Hollis

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH April 4, 1866
(Month) (Day) (Year)

7 AGE 64 yrs. 2 mos. 4 ds. or min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Consul General
(b) General nature of industry business, or establishment in which employed or (employer) USA.

9 BIRTHPLACE (State or country) Mass.

10 NAME OF FATHER George Hollis

11 BIRTHPLACE OF FATHER (State or country) Mass.

12 MAIDEN NAME OF MOTHER Summers

13 BIRTHPLACE OF MOTHER (State or Country) Mass.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Davidsoy Hollis

(Address) 4400 E. Elm St. Ch. Ch. Md

15 Filed June 10 1923 Benj. C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 8, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 3rd 1929 to June 8th 1930

that I last saw him alive on June 8th 1930

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH * was as follows:

Cerebral hemorrhage

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory Secondary Chronic arterio sclerosis

(Signed) Benj. C. Perry M. D.
June 9 1930 (Address) Bethesda, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Arlington National Cemetery DATE OF BURIAL June 11, 1930

20 UNDERTAKER W. P. Humphrey Jr ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 5 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

near Beallsville

(No. _____)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

213

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Unnamed infant (Honeyman)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*Wego*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)*Single*

6 DATE OF BIRTH

Dec 21, 1930
(Month) (Day) (Year)

7 AGE

yrs.

mos.

1

ds.

or

min.)

If LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Fletcher Honeyman

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Williamina Payne

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Williamina Payne

(Address)

R T D Bellman

15

Filed

12/23

1930

Wm D. Payne

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 22, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

at Birth 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

*Cyanosis neonatorum
Congenital myopathy*

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

W. D. Payne

M. D.

12/23 1930 (Address) *Wm D. Payne*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Poolsville**Dec 24, 1930*

20 UNDERTAKER

ADDRESS

*C. H. Davis**Poolsville Md*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the **EASE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro-pulmonary fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia", *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data it essentially and must be obtained before the certificate is permanently filed.

JAN 6 1901
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			12554		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgomery</u>			(74-2)		Registration Dist. No. <u>215</u>	
Village or City <u>Gaithersburg</u>			St. _____ Ward _____		(if death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Rev. Wm P. Hopkins</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>M.</u>	4 COLOR OR RACE <u>col.</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>married</u>	16 DATE OF DEATH <u>Oct 4</u> , 19 <u>30</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>July ?</u> , 18 <u>70</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended the deceased from <u>1930</u> to <u>Oct 4</u> , 19 <u>30</u> , that I last saw him alive on <u>Sept 27</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>8:30 A.M.</u>			
7 AGE <u>about 59</u> ³ / ₄ yrs. <u>4</u> mos. <u>-</u> ds.			If LESS than 1 day - hrs. or - min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Laborer + Preacher</u>			The CAUSE OF DEATH * was as follows: <u>Dist. when I arrived (probably acute cerebral hemorrhage)</u> (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. <u>died suddenly.</u>			
9 BIRTHPLACE (State or country) <u>Pa.</u>			Contributory Secondary (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. (Signed) <u>Stanley W. Barber</u> , M. D. <u>10/6/30</u> (Address) <u>Gaithersburg, Md.</u>			
PARENTS	10 NAME OF FATHER <u>Don't know.</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
	11 BIRTHPLACE OF FATHER (State or country) <u>Don't know.</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>10</u> yrs. <u>-</u> mos. <u>-</u> ds. In the State <u>same</u> yrs. <u>-</u> mos. <u>-</u> ds.			
	12 MAIDEN NAME OF MOTHER <u>Don't know.</u>		Where was disease contracted, if not at place of death? <u>Same</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Don't know.</u>		Former or usual residence <u>Same.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sarah Hopkins</u> (Address) <u>Gaithersburg, Md.</u>						
15 Filed <u>10/6</u> , 19 <u>30</u> <u>Paul D. E. Union</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>Gaithersburg, Md.</u>		DATE OF BURIAL <u>10/6/30</u>	
			20 UNDERTAKER <u>E. C. Vartner</u>		ADDRESS <u>Gaithersburg, Md.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

RECEIVED

WRITE MAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery Co

Village or City Sandy Spring (No. 1)

2 FULL NAME Miss named Stillborn Hopkins

08155

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217St. 2 Ward 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Infant
(Write the word)

6 DATE OF BIRTH July 14, 1930
(Month) (Day) (Year)

7 AGE Born Dead If LESS than 1 day hrs. yrs. 0 mos. 0 ds. or 0 min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Montgomery

10 NAME OF FATHER John Hopkins

11 BIRTHPLACE OF FATHER (State or country) Montgomery Co

12 MAIDEN NAME OF MOTHER Luey Hall

13 BIRTHPLACE OF MOTHER (State or Country) Montgomery Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. M. Leding

(Address) Brookville Md

15 Filed July 17, 1930 C. S. Carnsley
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1930
at Birth (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192, that I last saw him alive on Dead, 192

and that death occurred on the date stated above, at m. The CAUSE OF DEATH * was as follows:

Prolonged Labor
Obstetrical peritonitis

2 1/2 (Duration) yrs. 0 mos. 0 ds.

Contributory
Secondary

Instrumental delivery

(Duration) yrs. 0 mos. 0 ds.
(Signed) C. M. Leding M. D.

July 14, 1930 (Address) Brookville Md

*State the cause causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 0 mos. 0 ds. In the State yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandy Spring

July 14, 1930

20 UNDERTAKER

ADDRESS

John Hopkins

July 14-30

Sandy Spring

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Pajotman, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (c) Scalesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *A none.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACS should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Takoma Park (No. Washington Sanatorium Ward)

2 FULL NAME HORAK - INFANT & hospital

01813

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 223

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Feb. 13, 1920
(Month) (Day) (Year)

7 AGE 7 mos. If LESS than 1 day 4 1/2 hrs. 4 min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Montgomery

10 NAME OF FATHER Anton Horak

11 BIRTHPLACE OF FATHER (State or country) Czechoslovakia

12 MAIDEN NAME OF MOTHER Makresky, Mary

13 BIRTHPLACE OF MOTHER (State or Country) Czechoslovakia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Madred E. Warren
(Address) Washington Sanatorium

15 Filed Feb. 17 1920 Takoma D.C.
E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 13, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 13 - 1920 to Feb 13, 1920, that I last saw him alive on Feb 13, 1920, and that death occurred on the date stated above, at Washington Sanatorium m.

The CAUSE OF DEATH * was as follows:

Perinatal - 6 1/2 months
(Duration) yrs. mos. ds.

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) W. S. Mitchell M. D.
Feb 13 1920 (Address) Silver Spring Md.

*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. 4 1/2 hrs. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL I give permission to DATE OF BURIAL Feb 13 1920

20 UNDERTAKER W. S. H. to dispose my daughter ADDRESS Anton Horak

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

MAR 4 1930

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ictantion," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County Montgomery

10541

(47)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213Village or City Rockville (No. Chestnut Lodge Sanitarium Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Laura M. Hoskinson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Feb 9 1855
(Month) (Day) (Year)

7 AGE 75 yrs. 7 mos. 6 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Alexander McFarland

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bethany Lanham

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H. Hoskinson(Address) Rockville Md.

15 Filed 9-15 1926 Mrs. H. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 15 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept. 15 1930

that I last saw her alive on Sept. 15 1930

and that death occurred on the date stated above, at 5:30 m.

The CAUSE OF DEATH * was as follows:

Carcinoma of Breast.

(Duration) 2 yrs. ____ mos. ____ ds.
Contributory Hemorrhage
Secondary

(Signed) Dr. M. Bullard M. D.
Sept 15 1930 (Address) Rockville Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. 3 mos. 27 ds. In the 34 yrs. 9 mos. 1 ds.

Where was disease contracted, if not at place of death? at home

Former or usual residence Rockville Maryland

19 PLACE OF BURIAL OR REMOVAL (DATE OF BURIAL)
Polmar Md Sept 18 1930

20 UNDERTAKER (ADDRESS)
W. P. Pumphrey Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

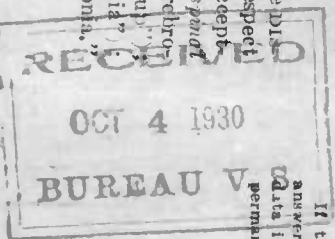
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Deleter," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Woman at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Males; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A 10th card is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE MAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Derwood (No. 19-a)

2 FULL NAME Excel R. Hollinger

01812 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Mar 17, 1929
(Month) (Day) (Year)

7 AGE 0 yrs. 10 mos. 29 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) MD

10 NAME OF FATHER Wilbur V. Hollinger

11 BIRTHPLACE OF FATHER (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Virginia F. Brady

13 BIRTHPLACE OF MOTHER (State or country) W. Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wilbur V. Hollinger

(Address) Derwood, Md.

15 Filed Feb 15, 1930 Rachel Van Cleave
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 15 Feb. 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 6 Feb. 1930 to 15 Feb. 1930
that I last saw him live on 14 Feb. 1930

and that death occurred on the date stated above, at 12:30 P. m.
The CAUSE OF DEATH * was as follows:

Lobar Pneumonia

(Duration) 0 yrs. 0 mos. 9 ds.

Contributory
Secondary

(Signed) Stanley W. Barber M. D.
15 Feb 30 (Address) Fairfax, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 10 mos. 29 ds. In the State Same yrs. mos. ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL Redland, Md. DATE OF BURIAL 15 Feb. 1930

20 UNDERTAKER Roy Barber Laytonville ADDRESS Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 7 1904
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont.

0573

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217Village or City Brighton (No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sarah Howard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED wid -
(Write the word)

6 DATE OF BIRTH 1848
Unknown
(Month) (Day) (Year)

7 AGE 82 yrs. 0 mos. 0 ds. or min.?
If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work home
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER Chas Allen

11 BIRTHPLACE OF FATHER (State or country) md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) Montgomery Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maggie Thorn
(Address) Brighton md

15 Filed Jan 6 1930 Mrs C S Barnesley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 2nd, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 22nd 1929 to Aug 31st, 1929, that I last saw her alive on Aug 31st, 1929,

and that death occurred on the date stated above, at 6:30 P m.
The CAUSE OF DEATH * was as follows:

Cerebral Arteriosclerosis
(Duration) 5 yrs. 0 mos. 0 ds.
Contributory Cerebral Hemorrhage
Secondary (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) Charles M. Olson M. D.
Jan 5 1930 (Address) Sandy Spring Md

*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

place of death md. In the State md. yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rockbeck Cem DATE OF BURIAL Jan 6th, 1930

20 UNDERTAKER Leo Snowden ADDRESS Rockville Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

few issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lebot pneumonia*, *Bronchopneumonia* ("Pneumonia");

FEB 5 1930

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE ONLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Takoma Park (No. 13)

Westmoreland Ave

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Registration Dist. No. 223

2 FULL NAME

WILLIAM ROBERT HOWELL

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

March 7, 1887
(Month) (Day) (Year)

7 AGE

43 yrs. 3 mos. 16 ds. or min.?

If LESS than 1 day... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed or (employer)

Marine Engineer

9 BIRTHPLACE

(State or country)

Nova Scotia, Canada

10 NAME OF FATHER

John W. HOWELL

11 BIRTHPLACE OF FATHER

(State or country)

Nova Scotia

12 MAIDEN NAME OF MOTHER

Lydia L. Hamell

13 BIRTHPLACE OF MOTHER

(State or country)

Nova Scotia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. W. B. Leavelle

(Address)

Westmoreland Ave

15

Filed June 23, 1930

H. E. Rogers

Registrar

06837

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

JUNE 23, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

June 11, 1930 to June 23, 1930.

that I last saw him alive on June 21, 1930.

and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH * was as follows:

Acute dilatation of heart

Contributory
Secondary

Coronary thrombosis

(Signed) Wm. Arthur Shannon M. D.

June 1930. (Address) 113 Carroll St. Takoma Park D.C.

*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Boston, Mass.

DATE OF BURIAL

June 24, 1930

20 UNDERTAKER

S. H. Hines Co

ADDRESS

2901 14th St. N.W.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farm* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Coal engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as *Asthenia*, *Anaemia* (merely symptom-atic), *Atrophy*, *Collapse*, *Cema*, *Convulsions*, *"Debility"* ("Congenital," *Scald*, etc.), *"Dropsy"*, *Exhaustion*, *"Heart failure"*, *"Haemorrhage"*, *"Inanition"*, *"Marasmus"*, *"Old Age"*, *"Shock"*, *"Trauma"*, *"Weakness"*, etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as *"PUERPERAL septicemia"*, *"PUERPERAL peritonitis"*, etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A) the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 5 1930

BUREAU

MARGIN RESERVED FOR BINDING

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<p>1 PLACE OF DEATH County <u>Montgomery</u></p>			<p>12876 STATE OF MARYLAND CERTIFICATE OF DEATH</p>		
<p>Village or City <u>Danvers</u> (No. _____) St. _____ Ward _____</p>			<p>Registration Dist. No. <u>213</u></p>		
<p>2 FULL NAME <u>Stillborn foetus Hubble</u></p>					
<p>PERSONAL AND STATISTICAL PARTICULARS</p>					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____			
6 DATE OF BIRTH <u>Oct 31 1930</u> (Month) (Day) (Year)					
7 AGE ____ yrs. ____ mos. ____ ds. or ____ min. If LESS than 1 day ____ hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work _____ (b) General nature of industry business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Harry Hubble</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Va</u>				
	12 MAIDEN NAME OF MOTHER <u>Catherine T. Hubble</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
<p>(Informant) <u>Harry Hubble</u> (Address) <u>R.F.D. Gaithersburg MD</u></p>					
15 Filed <u>for reg.</u> 1930 <u>Wm. J. Lawrence</u> Registrar					
<p>MEDICAL CERTIFICATE OF DEATH</p>					
16 DATE OF DEATH <u>Oct 31 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from _____ 192____ to _____ 192____, that I last saw him _____ alive on _____ 192____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows: <u>Prenatal birth</u>					
<p>(Duration) _____ yrs. _____ mos. _____ ds.</p>					
Contributory Secondary					
<p>(Signed) <u>Wm. J. Lawrence</u> M. D. <u>Wm. J. Lawrence</u> 1930 (Address) <u>Gaithersburg Md</u></p>					
<p>*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.</p>					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)					
<p>At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.</p>					
Where was disease contracted, if not at place of death? _____					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL				DATE OF BURIAL	
<u>Disposed of in waste</u>				____, 19____	
20 UNDERTAKER				ADDRESS	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic nodular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Insanition," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 11 1920

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Beallsville (No. _____)

2 FULL NAME Harry P. Huddleson

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH 6 17 1865
(Month) (Day) (Year)

7 AGE 65 yrs. 4 mos. 15 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Constructor
(b) General nature of industry, business, or establishment in which employed or (employer) Building

9 BIRTHPLACE (State or country) Pa.

10 NAME OF FATHER John Huddleson

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Patterson

13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. H. P. Huddleson
(Address) 1651 Columbia Rd. Washington, D.C.

15 Filed 11/16 1930 Upton S. Howell Dep. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 - 16 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov. 14 1930 to Nov. 16 1930
that I last saw him alive on Nov. 16 1930

and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH * was as follows:

Coronary Thrombosis

(Duration) ____ yrs. ____ mos. 2 ds.
Contributory Secondary Myocarditis

(Signed) Upton S. Howell M. D.
11/16 1930 (Address) Damronville Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rock Creek Cemetery 11/18 1930
Washington, D.C.
UNDERTAKER John Wright ADDRESS 1820 St. N. W.
D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Lumber—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1930

BUREAU

WRITE PLAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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PLACE OF DEATH

County

Montgomery

03103

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

Village or City

Bethesda

(No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME

Nathan Aberdeen Hudson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

W

6 DATE OF BIRTH

January 6, 1857

(Month)

(Day)

(Year)

7 AGE

76 yrs. 2 mos. 4 ds. or min.?

If LESS than

1 day ____ hrs.

min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Foliosist

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Frammingham, Mass

10 NAME OF FATHER

Nathan Hudson

11 BIRTHPLACE OF FATHER

(State or country)

Massachusetts

12 MAIDEN NAME OF MOTHER

Hannah Keitt

13 BIRTHPLACE OF MOTHER

(State or Country)

Mass.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles M. Hudson

(Address)

Bethesda

15

Filed

March 11, 1930 Ben C. Perry, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Mar. 10, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

March 9, 1930 to March 10, 1930

that I last saw him alive on March 10, 1930

and that death occurred on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH * was as follows:

General debility, arterio sclerosis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) _____ M. D.

3/11/30 192 ____ (Address) _____

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Natick, Mass

3/12, 1930

20 UNDERTAKER

ADDRESS

W R Humphrey Jr.

Rockville

md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

08156

(48)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213Village or City Potomac (No. _____)

St.: _____ Ward: _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary E. Hughes

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH <u>July 4, 1845</u> (Month) (Day) (Year)
--

7 AGE <u>85 yrs. 0 mos. 16 ds.</u>	IF LESS than 1 day. hrs. or. min.?
---------------------------------------	--

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) <u>Maryland</u>

10 NAME OF FATHER <u>John Nizer</u>
--

11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
--

12 MAIDEN NAME OF MOTHER <u>Unknown</u>
--

13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>
--

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Emma J. Stearn(Address) Potomac, Md.15 Filed July 22, 1930 Mrs. W. T. Crall

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>July 20th, 1930</u> (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from <u>1928</u> 192... to <u>July 20</u> , 1930.
--

that I last saw him alive on July 20, 1930.and that death occurred on the date stated above, at 1 P. m.

The CAUSE OF DEATH * was as follows:

Carcinoma of lower jaw & throat. Epithelioma, primary in skin on side of jaw, finally penetrating into mandible & soft tissue. Duration 4 yrs. 4 mos. 4 ds.

Contributory
Secondary

Myocardial failure
(Duration) 1 yrs. 1 mos. 1 ds.
(Signed) R. Shively Jones M.D.

7/21/30 192... (Address) 4415 Chesapeake
State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. D.C.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.	In the State yrs. mos. ds.
------------------------------------	-------------------------------

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Potomac M. E. Church Cemetery July 22, 1930
ADDRESS

20 UNDERTAKER
Harold Humphrey Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bro. chpneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
MAY 6 1922
BUREAU

MARGIN RESERVED FOR BINDING

WRITE AGAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Montgomery

Village or City Cherry Chase (No. _____)

² FULL NAME John R. Hutchison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Jan. 16, 1884
(Month) (Day) (Year)

7 AGE 86 yrs. 6 mos. 8 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Thomas Hutchison

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary E. Eist

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Hutchison

(Address) Cherry Chase, Md.

¹⁵ Filed Aug 25, 1930 Benj. C. Perry
Registrar

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 24th, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 2, 1930 to Aug 24, 1930
that I last saw him alive on Aug 24, 1930
and that death occurred on the date stated above, at 7:30 P.m.

The CAUSE OF DEATH * was as follows:
General debility, senility

Contributory Secondary Chronic arteriosclerosis
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Benj. C. Perry M. D.
Aug 24, 1930 (Address) Berlinda, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Leesburg, Va. Aug 26, 1930

20 UNDERTAKER ADDRESS

Warner E. Pumphrey, Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery Co</u>			05705			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Seamans</u> (No. _____)			St. _____			Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>John T. Hutchinson</u>			Registration Dist. No. <u>212</u>					
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)						
6 DATE OF BIRTH <u>Aug. 8, 1833</u> (Month) (Day) (Year)								
7 AGE <u>96</u> yrs. <u>8</u> mos. <u>14</u> ds. or <u>LESS</u> than 1 day _____ hrs. _____ min.								
8 OCCUPATION (a) Trade, profession or particular kind of work <u>farm labor</u> (b) General nature of industry business, or establishment in which employed or (employer) _____								
9 BIRTHPLACE (State or country) <u>Va.</u>								
10 NAME OF FATHER <u>Isaac Hutchinson</u>								
11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u>								
12 MAIDEN NAME OF MOTHER <u>Unknown</u>								
13 BIRTHPLACE OF MOTHER _____ (State or Country)								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lauria Hutchinson</u> (Address) <u>Seamans, Md</u>								
15 Filed <u>May 25</u> 19 <u>80</u> by <u>Mrs. C. C. Hellow</u> Registrar								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>May 22, 1930</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from _____ 192____ to _____ 192____, that I last saw him alive on _____ 192____, and that death occurred on the date stated above, at <u>5:30</u> a.m. The CAUSE OF DEATH * was as follows: <u>Myocarditis</u> (Duration) _____ yrs. _____ mos. _____ ds.								
Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.								
(Signed) <u>T. R. Gungah</u> M. D. <u>May 15, 1930</u> (Address) <u>Barnesville</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____								
19 PLACE OF BURIAL OR REMOVAL <u>mt. Zion in Barnesville</u>						DATE OF BURIAL <u>May 25, 1930</u>		
20 UNDERTAKER <u>W. T. Hixon Sons</u>						ADDRESS <u>Barnesville</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery Co., Md.

04462

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214Village or City Silver Spring (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Charles G. Hyslop

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widower
(Write the word)

6 DATE OF BIRTH

Jan 9, 1853
(Month) (Day) (Year)

7 AGE

77 yrs. 3 mos. 24 ds. or _____ min.?
If LESS than 1 day _____ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed or (employer)retired9 BIRTHPLACE
(State or country)London England

10 NAME OF FATHER

Joseph Sounder Hyslop11 BIRTHPLACE OF FATHER
(State or country)England

12 MAIDEN NAME OF MOTHER

Katherine Lambert13 BIRTHPLACE OF MOTHER
(State or country)England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

C. Hyslop
Silver Spring Md.

15

Filed April 3 1930 J. E. Dunning
D. Fly Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 2, 1930
(Month) (Day) (Year)17 WHEREBY CERTIFY, That I attended the deceased from Feb 20 1930 to April 2, 1930that I last saw him alive on April 1, 1930and that death occurred on the date stated above, at 2 P m.

The CAUSE OF DEATH * was as follows:

arteriosclerosis
myocarditis (Duration) _____ yrs. _____ mos. _____ ds.
Contributory edema of
Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Alfred Parsons M. D.
April 3, 1930 (Address) 249 Carroll St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington DC April 4, 1930

20 UNDERTAKER

ADDRESS

Frank Seiers Sons 1113-7th St W
Wash. DC

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Teamster," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); "Typhoid fever (never report "Typhoid Pneumonia"); "Scarlatina pneumonia. Bronchopneumonia ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.; Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by hydrocyanic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 9 1930
BUREAU

Parasitology

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County MTG

Village or City Felton Spring (No. _____)

2 FULL NAME Harriet Hyeon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH ? ? 1862
(Month) (Day) (Year)

7 AGE 68 yrs. ? mos. ? ds. or min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) MD.

10 NAME OF FATHER Henry Bowie

11 BIRTHPLACE OF FATHER (State or country) MD.

12 MAIDEN NAME OF MOTHER Margaret Peterson

13 BIRTHPLACE OF MOTHER (State or country) MD.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Char Hyeon
(Address) Felton Spring, Md.

15 Filed Dec. 4 1930 J. E. Duddy, Jr.
Registrar

15153 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 12, 1930.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 28, 1930, to Dec 12, 1930 that I last saw her alive on Nov 30, 1930 and that death occurred on the date stated above, at 10³⁰ A. M. The CAUSE OF DEATH * was as follows:

Hypertension
(Duration) 5 yrs. 0 mos. 0 ds.
Contributory Chronic tonsillitis
Secondary (Duration) 3 yrs. 0 mos. 0 ds.

(Signed) W. R. Hyeon M. D.
Dec 12 1930 (Address) Felton Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Forest Glen DATE OF BURIAL 12, 4, 1930

20 UNDERTAKER E. Humphrey ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by acetic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Barnesville

2 FULL NAME Albert C. Imes

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH August 12th, 1896
(Month) (Day) (Year)

7 AGE 34 yrs. 1 mos. 14 ds. or LESS than 1 day _____ hrs. _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER John Imes

11 BIRTHPLACE OF FATHER (State or country) Va.

12 MAIDEN NAME OF MOTHER Bertha Thompson

13 BIRTHPLACE OF MOTHER (State or Country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary F. Imes

(Address) Barnesville, Md.

15 Filed Sept 29 1920 W. S. Brown Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 27th, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from August 1st 1920 to Sept 27th, 1920, that I last saw him alive on Sept 27th, 1920,

and that death occurred on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH * was as follows: Chronic interstitial nephritis

Contributory Unknown
Secondary Autumnal Fever
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. P. Hicks M. D.
Sept 29th 1920 (Address) Hickerson

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Martinsburg Md. DATE OF BURIAL Sept. 30, 1920

20 UNDERTAKER Harmon E. Humphrey ADDRESS Seville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, (as fracture of skull, and consequences (e. g., *sepsis, tetanus*)) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Oct 4 1930

RECEIVED

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

09382

74a

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Bethesda (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Vincent Dippolito

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
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6 DATE OF BIRTH <u>Aug 17</u> (Month) (Day) (Year)	<u>1866</u>
--	-------------

7 AGE <u>63</u> yrs. <u>4</u> mos. <u>3</u> ds.	If LESS than 1 day ____ hrs. ____ min.?
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8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)	<u>Broker</u>
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9 BIRTHPLACE (State or country)	<u>Italy</u>
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10 NAME OF FATHER	<u>Francis Dippolito</u>
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11 BIRTHPLACE OF FATHER (State or country)	<u>Italy</u>
---	--------------

12 MAIDEN NAME OF MOTHER	<u>Grace Catalano</u>
--------------------------	-----------------------

13 BIRTHPLACE OF MOTHER (State or Country)	<u>Italy</u>
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14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rose M. Dippolito
(Address) Bethesda, Md.

15 Filed <u>Aug 18th 1923</u>	<u>Benj. C. Perry</u> Registrar
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MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>Aug. 17, 1923</u> (Month) (Day) (Year)
--

17 I HEREBY CERTIFY That I attended the deceased from <u>Aug 16 1923</u> to <u>Aug 17 1923</u>

that I last saw him alive on Aug 17 1923and that death occurred on the date stated above, at 6:30 p.m.The CAUSE OF DEATH * was as follows:
Cerebral hemorrhage

(Duration) ____ yrs. ____ mos. <u>3</u> ds.

Contributory
Secondary

(Signed) <u>E. G. Bauerzfeld</u> M. D.	(Duration) ____ yrs. ____ mos. ____ ds.
<u>Aug 18 1923</u> (Address) <u>Bethesda, Md.</u>	

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. 4 mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.Where was disease contracted, if not at place of death? At homeFormer or usual residence 9000 Pk. - Melrose Av.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

<u>St. Mary's Cemetery</u>	<u>Aug 19, 1923</u>
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20 UNDERTAKER Wash. D. C. ADDRESSWarner E. Humphrey Rockville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E.haustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontVillage or City Olney(No. Mont Co Gen Hosp) St. _____Registration Dist. No. 217

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Dale Isenberg

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>m</u>	4 COLOR OR RACE <u>w</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH Oct 15, 1929
(Month) (Day) (Year)7 AGE 10 yrs. 17 mos. 17 ds. or 1 day 17 hrs. min.?8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) md10 NAME OF FATHER Roy Isenberg11 BIRTHPLACE OF FATHER (State or country) va12 MAIDEN NAME OF MOTHER Chlo Bethis13 BIRTHPLACE OF MOTHER (State or country) va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chlo Isenberg(Address) Derwood R 2015 Filed Sept 3, 1930 Ch Barnsley Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

10543

(16-F)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 2, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Aug 31-30, 1929 to Sept 2, 1930that I last saw him alive on Sept 2, 1930and that death occurred on the date stated above, at 9:30 a.m.
The CAUSE OF DEATH * was as follows:Acute Dysentery, bacillary.(Duration) 5 yrs. 5 mos. 5 ds.Contributory Malnutrition
Secondary(Duration) 9 yrs. 9 mos. 9 ds.(Signed) CC Summerson M. D.Sept 2, 1930 (Address) Sandy Spring Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Manner of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 2 yrs. 2 mos. 2 ds. In the life State va yrs. 2 mos. 2 ds.Where was disease contracted, home
if not at place of death?Former or usual residence Derwood R 20

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cathart va Sept 4, 1930

20 UNDERTAKER

ADDRESS

Roy W Barbey Smithersburgfor issuedmd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Butcher*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc.. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Assthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data are essential and must be obtained before the certificate is permanently filed.

RECEIVED

OCT 4 1930

FULL

MARGIN RESERVED FOR BINDING
WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

10544
(161-2)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Lakoma Park (No. Holly Ave Ext-1-)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME, instead of street and number.)

2 FULL NAME Andrew Thornton Jack

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Aug 31st, 1930
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day 23 hrs. _____ yrs. _____ mos. XX ds. or _____ min.?

8 OCCUPATION
a) Trade, profession or particular kind of work none
b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Warrenton Vivian Jack

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bertha Ophelia Gaylor

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. M. V. Jack
(Address) Holly Ave Ext.

15 Filed Sept 1 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 1st, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 31st 1930 to Sept 1st 1930, that I last saw him alive on Sept 1st 1930

and that death occurred on the date stated above, at 4:10 P. m. The CAUSE OF DEATH * was as follows:

Atelactasia - affecting head & lungs -

(Duration) _____ yrs. _____ mos. 1 ds.

Contributory Secondary Pneumonia Infant

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Lauritta E. Kress M. D.
Sept 1 1930 (Address) Lakoma Park and

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Cedar Hill Cemetery Sept 2 1930

20 UNDERTAKER ADDRESS
H. B. Nevins 2414 York Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Colesville (No. _____) St. _____ Ward _____

2 FULL NAME Ada F. Jackson

04463

(129)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH Feb 21 1 1844
(Month) (Day) (Year)

7 AGE 86 yrs. 1 mos. 26 ds. or min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Virginia
10 NAME OF FATHER Thomas R. Foulke

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Weaver

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Lamar Jackson

(Address) Colesville, Md.

15 Filed April 17, 1931 C. S. Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4/17/1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 3/20/1930 to 4/17/1930, that I last saw him alive on 4/10/1930, and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

General Arteriosclerosis

Chronic interstitial nephritis, aged 67

(Duration) 5 yrs. ____ mos. ____ ds.

Contributory
Secondary Insomnia

(Duration) ____ yrs. ____ mos. 7 ds.

(Signed) J. M. Bird M. D.

4/17/1930 (Address) Sandy Spring

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Colesville, Md.

April 18, 1930

20 UNDERTAKER

ADDRESS

Warner & Humphrey, Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

per issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Lipthleria* (avoid use of "Grip"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1930
BUREAU V. B.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Bethesda (No. 742)10545 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Emma Jackson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>female</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
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6 DATE OF BIRTH <u>45</u> yrs. <u>1</u> mos. <u>1</u> ds. or min.?	(Month) _____ (Day) _____ (Year) _____
---	--

7 AGE <u>45</u> yrs. <u>1</u> mos. <u>1</u> ds. or min.?	If LESS than 1 day _____ hrs. _____ min.?
---	---

8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)	<u>Housewife</u>
--	------------------

9 BIRTHPLACE (State or country)	<u>Virginia</u>
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10 NAME OF FATHER	<u>unknown</u>
-------------------	----------------

11 BIRTHPLACE OF FATHER (State or country)	<u>Virginia</u>
--	-----------------

12 MAIDEN NAME OF MOTHER	<u>unknown</u>
--------------------------	----------------

13 BIRTHPLACE OF MOTHER (State or Country)	<u>unknown</u>
--	----------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)	<u>Frank Jackson</u>
(Address)	<u>Bethesda, Md.</u>

15 Filed <u>9-5</u> 19 <u>30</u>	<u>Benj. @. Perry</u> Registrar
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MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>Sept. 5th</u> , 19 <u>30</u>	(Month) _____ (Day) _____ (Year) _____
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17 I HEREBY CERTIFY, That I attended the deceased from <u>Sept 4th</u> 19 <u>30</u> to <u>Sept 5th</u> 19 <u>30</u> , that I last saw her alive on <u>Sept 4th</u> 19 <u>30</u> , and that death occurred on the date stated above, at <u>5 a.</u> m.
--

The CAUSE OF DEATH * was as follows:

<u>Cerebral hemorrhage</u>

(Duration) _____ yrs. _____ mos. <u>1</u> ds.

Contributory
Secondary

(Signed) <u>E. G. Bauerfeld</u> M. D. <u>Sept. 5, 1930</u> , (Address) <u>Bethesda, Md.</u>
--

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds.	In the State _____ yrs. _____ mos. _____ ds.
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Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL <u>Wash. D.C.</u>	DATE OF BURIAL <u>8/5</u> , 19 <u>30</u>
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20 UNDERTAKER <u>W. E. Carver</u>	ADDRESS <u>1432-20 st NW</u>
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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, House-keeper, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the date is essential and must be obtained before the certificate is permanently filed.

RECEIVED

05

BUR

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Cherry Chase (No. 106, Raymond)

Registration Dist. No. 216

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mary A. Jackson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

May 4, 1857
(Month) (Day) (Year)

7 AGE

71 yrs. 10 mos. 10 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Washington D.C.

PARENTS

10 NAME OF FATHER

Charles G. Golbrook

11 BIRTHPLACE OF FATHER

(State or country)

Washington D.C.

12 MAIDEN NAME OF MOTHER

Ledia Clancy

13 BIRTHPLACE OF MOTHER

(State or country)

Wash. D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Frank H. Jackson

(Address)

106 Raymond St.

15

Filed 3/15/30 191

Benj. C. Perry

REGISTRAR

03104

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 14th, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY That I attended deceased from
Mch. 14, 1930, to Mch. 14, 1930.that I last saw her ^{dead} alive on Mch. 14, 1930
Coroner viewed body
and that death occurred on the date stated above, at 10:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart.

(Duration) yrs. mos. 1 ds.

Contributory
Secondary(Signed) Wheeler O. Huff, M. D.
Mch. 15, 1930 (Address) Bethesda, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Congressional Cemetery, Wash. D.C. Mar. 17, 1930

20 UNDERTAKER

ADDRESS

John R. Knight Co 1337-10 St. N.Y.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, STUPIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Cherry Chase (No. 6405 Georgia St. Ward)

2 FULL NAME Iver O. Jacobson

13916
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widower

6 DATE OF BIRTH July 4th 1884
(Month) (Day) (Year)

7 AGE 89 yrs. 4 mos. 19 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Building Contractor
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Norway

10 NAME OF FATHER Jacob Hanson

11 BIRTHPLACE OF FATHER (State or country) Norway

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or Country) Norway

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edwin Jacobson
(Address) 6405 Georgia St.

15 Filed Nov 23, 1930 Benj C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 23, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov. 1, 1930 to Nov. 23, 1930
that I last saw him alive on Nov. 23, 1930

and that death occurred on the date stated above, at 8:45 p. m.
The CAUSE OF DEATH * was as follows:

Chronic myocarditis and arteriosclerosis
(Duration) 3 yrs. — mos. — ds.

Contributory
Secondary

(Signed) E. G. Bayersfeld M. D.
Nov. 23, 1930 (Address) Bethesda, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore, Md. DATE OF BURIAL Nov. 25, 1930

20 UNDERTAKER Marshall ADDRESS Falls Rd., Balto., Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Retired (year retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the facts are essential and must be obtained before the certificate is permanently filed.

DEC 6 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Takoma Park, Md. (No. 44)

Washington San. St. Hosp. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mr. Albert H. Jarman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH April 27, 1875
(Month) (Day) (Year)

7 AGE 55 yrs. — mos. 31 ds. or — min. 2
If LESS than 1 day

8 OCCUPATION
(a) Trade, profession or particular kind of work lawyer
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) San Jose Calif.

10 NAME OF FATHER John P. Jarman

11 BIRTHPLACE OF FATHER (State or country) Engl.

12 MAIDEN NAME OF MOTHER Jane Holchingson

13 BIRTHPLACE OF MOTHER (State or Country) Oregon

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington San. & Hosp. Files

(Address) Takoma Park, Md.

15 Filed May 28 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 2, 1930 to May 28, 1930,

that I last saw him alive on May 28, 1930,

and that death occurred on the date stated above, at 120 a.m.

THE CAUSE OF DEATH * was as follows:

Carcinoma of Stomach

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) W. E. Rogers M. D.

192 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 1 mos. 26 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Backque Club, Washington DC

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

S. A. Hines Co May 28, 1930

20 UNDERTAKER

ADDRESS

2901 - 14 Ave Washington DC

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired '6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 4 1930

N.B.--Every item of information should be carefully supplied. ACE should be stated ACTUALLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

01814

STATE OF MARYLAND CERTIFICATE OF DEATH

(129)

Registration Dist. No. 223

1 PLACE OF DEATH

County

Montgomery

Village or City

Lakona Park, Md. Wash. Say. Hosp.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mrs. Grace P. Jenkins

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Female White

6 DATE OF BIRTH

November 26 1882
(Month) (Day) (Year)

7 AGE

47 yrs. 2 mos. 17 ds. or min. If LESS than 1 day... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work.

Clerk

(b) General nature of industry business, or establishment in which employed or (employer).

Clerking

9 BIRTHPLACE

(State or country)

Washington D. C.

10 NAME OF FATHER

Joseph Jennings

11 BIRTHPLACE OF FATHER

(State or country)

Washington D. C.

12 MAIDEN NAME OF MOTHER

Annie E. O'Neil

13 BIRTHPLACE OF MOTHER

(State or country)

Washington D. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sanitarium Records

(Address)

Lakona Park, Md.

15

Filed

2/13 1930

192

H. E. Rogers

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 12, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Feb. 8, 1930 to Feb. 12, 1930that I last saw her alive on Feb. 12, 1930and that death occurred on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH * was as follows:

Hypertensive Cardiovascular Disease

Contributory Secondary

(Duration) 6 yrs. 1 mos. 1 ds.Cerebral Hemorrhage

(Signed)

Chas. H. Stolyarov, M.D.
2/12 1930 (Address) Lakona Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs... mos. 5 ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or actual residence 1473 Irving St. N.W. apt 23

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D. C. 2/13/1930

20 UNDERTAKER

ADDRESS

Wm. J. Nally 522 E. St. E.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

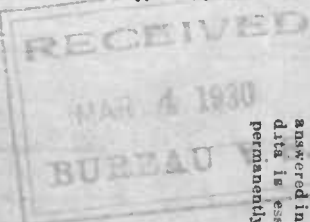
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Dealer," et., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Turner (retired 6 yrs)*. For persons who have no occupation whatever, write *Name*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by running train—accident; Renalier wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Elney (No. Montgomery to Suitcase) (1-a)
St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

08157 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

2 FULL NAME Benson Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 6/21/1930
(Month) (Day) (Year)

7 AGE 48 yrs. 0 mos. 24 ds. IF LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Iron Worker
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Benjamin Johnson

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Jane Adams

13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Smith

(Address) Elney Ind

15 Filed July 16 1930 Ed Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7/15/1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 6/20/1930 to 7/15/1930

that I last saw him alive on 7/15/1930

and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH * was as follows:

Typhoid Fever

Contributory (Duration) yrs. mos. 36 ds.
Secondary Intestinal Pyrexia

(Signed) John S. Jones M. D.
7/15/1930 (Address) Suitcase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. 30 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Elsenville Ind

19 PLACE OF BURIAL OR REMOVAL Ref. Colesville Ind

DATE OF BURIAL 7-17-1930

20 UNDERTAKER Des R. Brondau, Rockville Ind

ADDRESS

for record.

Ind

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Lymphatic* (avoid use of "Goup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Pnechopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 4 1930

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

County Montg.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218Village or City Gaithersburg (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Ellis Ray Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
----------------------	---------------------------------	---

6 DATE OF BIRTH Sept 8 (Month) (Day) (Year)	1908
--	-------------

7 AGE 22 yrs. 3 mos. 13 ds.	IF LESS than 1 day ____ hrs. or ____ min.?
---------------------------------------	--

8 OCCUPATION (a) Trade, profession or particular kind of work Clerk (b) General nature of industry, business, or establishment in which employed or (employer)
--

9 BIRTHPLACE (State or country) Md
--

10 NAME OF FATHER J Edgar Johnson

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Georgie M Cecil
--

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Edgar Johnson(Address) Gaithersburg, Md

15 Filed <u>Dec. 23</u> 19 <u>20</u>	<u>Wm. M. Ware</u> Registrar
--------------------------------------	---------------------------------

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12-21- 19 <u>20</u> (Month) (Day) (Year)
--

17 I HEREBY CERTIFY, That I attended the deceased from 10-17- 19 <u>20</u> to 12-21- 19 <u>20</u> that I last saw him alive on 12-21- 19 <u>20</u>

and that death occurred on the date stated above, at **11:45 P.M.**
The CAUSE OF DEATH * was as follows:Hodgkins Disease(Duration) **2** yrs. **+** mos. ____ ds.Contributory
Secondary

(Signed) <u>W. C. Miller</u> M. D. 12-22 19 <u>20</u> (Address) <u>Gaithersburg, Md</u>

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Gaithersburg, Md **Dec 24** 1920

2D UNDERTAKER ADDRESS

E C Gattner Gaithersburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Artist, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 6 1931

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicæmia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Rockville (No. 129)

2 FULL NAME Ethel R. Johnson

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

St. Gen Ward Hof (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Sept 3, 1898
(Month) (Day) (Year)

7 AGE 32 yrs. 7 mos. 28 ds. or min. If LESS than 1 day ~ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer) Same

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Jas. Carlisle

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Susie E. Carter

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. H. Carlisle

(Address) Rockville Md.

15 Filed Mar 2 1930 C. S. Barnsley
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1 Mar., 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1 Mar. 1930 to 1 Mar. 1930
that I last saw him alive on 1 Mar. 1930
and that death occurred on the date stated above, at 7:05 P. m.
The CAUSE OF DEATH * was as follows:

Chronic Myocarditis
about 7 yrs. 7 mos. ds.
Contributory phosphorus
Secondary about 3 yrs. 3 mos. ds.
(Signed) Stanley W. Carter M. D.
2 Mar 30 (Address) Yardley Md.

*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) 10 min.

At place of death 0 yrs. 0 mos. 0 ds. In the 22 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? Derrywood Md

Former or usual residence Derrywood Md.

19 PLACE OF BURIAL OR REMOVAL Rockville Md DATE OF BURIAL 3 Mar 30

20 UNDERTAKER Wm. R. Humphrey ADDRESS Rockville

Not issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 4 1930
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

05707

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Mt Zion (No.)

St. Ward) (If death occurred in

a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Henrietta Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

Colored

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

widowed

6 DATE OF BIRTH

Unknown

(Month)

(Day)

1

(Year)

7 AGE

Approximately 85 yrs.

mos.

ds.

or min.?

If LESS than

1 day

hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed or (employer).

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

Edmond Dorsey

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Abigail Tyler

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. Henry Johnson

(Address)

Rockville

15

Filed

May 9

1920

C. S. Barnsley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 7

1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Mar 25 1930 to May 7 1930

that I last saw him alive on May 5 1930

and that death occurred on the date stated above, at 12:20 a.m.

The CAUSE OF DEATH * was as follows:

Arterio Sclerotic Smully

(Duration) 2 yrs mos ds.

Contributory
Secondary

(Duration) yrs mos ds.

(Signed) J. H. Dixon M. D.

May 7 1930 (Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Zion

May 9 1930

20 UNDERTAKER

ADDRESS

George Swander

Rockville

If more blanks are needed, address State Registrar, 16 W. Sareoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Coal engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 4 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Mont

Village or City Rockville (No. _____)

² FULL NAME Isaac Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH unknown, 1850
(Month) (Day) (Year)

7 AGE 80 yrs. ____ mos. ____ ds. or ____ min. If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work minister
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) ind

10 NAME OF FATHER Isaac Johnson

11 BIRTHPLACE OF FATHER (State or country) ind

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or Country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Johnson
(Address) Rockville Md

15 Filed July 25 1930 Mrs. W. T. Cratt
Registrar

08158 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July, 1923
(Month) 21 (Day) (Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from 7/20 1923 to July 21, 1923

that I last saw him alive on July 21, 1923

and that death occurred on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH * was as follows:

Chronic Myocarditis

(Duration) 1 yrs. ____ mos. ____ ds.

Contributory Secondary Chronic Nephritis
unknown (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. E. Hawks M. D.
7/23 1923 (Address) Rockville Md

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Haiti, Maryland July 24, 1930

20 UNDERTAKER ADDRESS
George Snodder Rockville, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Hæmorrhage," "Imbition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Rockville (No. Autopsy)

2 FULL NAME James Johnson

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Negro 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single.

6 DATE OF BIRTH June Unknown, 1900
(Month) (Day) (Year)

7 AGE 30 yrs. — mos. — ds. or — min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Day laborer
(b) General nature of industry, business, or establishment in which employed or (employer) House cleaning

9 BIRTHPLACE
(State or country) Ind

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER
(State or country) Ind

12 MAIDEN NAME OF MOTHER Florence McIlhenny

13 BIRTHPLACE OF MOTHER
(State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Johnson

(Address) Rockville, Ind

15 Filed June 29 1930 Mrs. W. J. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 29, 1930.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dead when found to —, 1930,
that I last saw him alive on about, 1930,
and that death occurred on the date stated above, at 2-A m.
The CAUSE OF DEATH * is as follows:

Shock + haemorrhage,
chest crushed by hit abd-run
driver on Norbeck Pice

Contributory (Duration) ____ yrs. ____ mos. ____ ds.
Secondary Puncture heart, lungs
and liver.
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) N. J. Pratt M. D.
6/29 1930 (Address) Rockville Ind

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Norbeck Ind July 1, 1930

20 UNDERTAKER ADDRESS

Marner E. Pumphrey, Rock' Ind

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING
WRITE AIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Mont

08159

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217

Village or City Olney (No. Mont. Co Gen Hosp St. - Ward -) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

² FULL NAME Maril Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Apr 5, 1930
(Month) (Day) (Year)

7 AGE 3 yrs. 2 mos. 21 ds. or 1 day hrs. min. If LESS than 1 day

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) md -

10 NAME OF FATHER Archie Johnson

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER Viola Mahoney

13 BIRTHPLACE OF MOTHER (State or country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Archie Johnson

(Address) Salpines Md

15 Filed July 28 1930 C. S. Barber
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 26 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 23 1930 to July 26 1930

that I last saw her alive on July 26 1930

and that death occurred on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH * was as follows:

Enterocolitis

(Duration) 5 yrs. - mos. - ds.

Contributory Malnutrition
Secondary

(Duration) 3 yrs. - mos. - ds.

(Signed) C. S. Barber M. D.

July 27 1930 (Address) Sandy Spring Md

*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death - yrs. - mos. 3 ds. In the State life yrs. - mos. - ds.

Where was disease contracted, if not at place of death? home

Former or usual residence Salpines Md

19 PLACE OF BURIAL OR REMOVAL

Rockville Md DATE OF BURIAL July 28 1930

20 UNDERTAKER W. E. Humphrey ADDRESS Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 4 1930

MARGIN RESERVED FOR BINDING

WRITE WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Olney (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 212

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 12/7/1891
(Month) (Day) (Year)

7 AGE 38 yrs. 1 mos. 9 ds. or 1 day hrs. min. If LESS than 1 day

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) md.

10 NAME OF FATHER Frank Bentley

11 BIRTHPLACE OF FATHER (State or country) md.

12 MAIDEN NAME OF MOTHER Alvira Wilson

13 BIRTHPLACE OF MOTHER (State or country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Johnson
(Address) Collierville, Md

15 Filed Jan 19 1920 C. S. Barnsby
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11/16/1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 12/16/1920 to 1/16/1920

that I last saw her alive on 1/16/1920

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH * was as follows:

Pelvic Peritonitis, following an operation which was not successful.

(Duration) 1 yrs. 12 mos. 12 ds.

Contributory Secondary Broncho-Pneumonia

(Duration) 12 yrs. 12 mos. 12 ds.

(Signed) M. B. J. M. D.

11/18/1920 (Address) Sandy Spring, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 12 mos. 12 ds. In the State 1 yrs. 12 mos. 12 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hopkins Chapel DATE OF BURIAL Jan. 19, 1920

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*. (b) *Cotton mill*; (a) *Salesman*. (b) *Grocery*; (a) *Foreman*. (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

RECEIVED

FEB 5 1930

BU

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—occident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Blue (No. Montgomery Co. San Howard)

2 FULL NAME

Raymond Johnson

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

217

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

1905

(Month)

(Day)

1905
(Year)

7 AGE

25 yrs.

mos.

ds.

If LESS than
1 day hrs.
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country)10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Aug 24 1928

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

8/24/1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from
8/24/1930 to 8/24/1930

that I last saw him alive on 8/24/1930

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH * was as follows:

Comp. comminuted depressed
fracture of skullInjunct auto. accident at
Contributor
Secondary Edna M.

(Signed) J. M. Dent M. D.

192 (Address) Sandy Spring

*State the cause Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chenayth Md Aug 26 1930

20 UNDERTAKER

ADDRESS

Les P. Mordue Rockville Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Paupersman, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saleman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The maternal worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Asthma," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drepsy," "Ehaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 5 1900

MARGIN RESERVED FOR BINDING

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery Co

Village or City Fairland (No. _____)

2 FULL NAME Wilson G Johnson

12555

(44)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Sept 9 1859
(Month) (Day) (Year)

7 AGE 71 yrs. 1 mo. 9 ds. or min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed or (employer) Farmer

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Physius Johnson

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Must A. Walter

(Address) Paloma Pk Md

15 Filed Oct 19 1920 J. E. Wadley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 18 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1 1920 to Oct 18 1920, that I last saw him alive on Oct 18 1920

and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH * was as follows:

Carcinomatosis
Primary in stomach, with
metastases
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Cachexia
Secondary _____
(Duration) 2 yrs. _____ mos. _____ ds.

(Signed) J. W. D. M. D.
Oct 19 1920 (Address) Sandy Spring Md

*State the cause of death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Fairland Cem St Marks Ch. DATE OF BURIAL Oct 20 1920

20 UNDERTAKER Thomas J. Suggs ADDRESS 1011-1st St NW

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Printer, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association).

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Damascus (No. _____)

2 FULL NAME Infant Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____

6 DATE OF BIRTH 4-10-1930

(Month) (Day) (Year)

7 AGE 4 Mo. Premature If LESS than 1 day, hrs. _____

8 OCCUPATION (a) Trade, profession or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Samuel Connor

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Mildred J. Johnson

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mildred J. Johnson

(Address) Yemassee Rd Md

15 Filed 4/10/1930 by S. H. Johnson Registrar

04464

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4-10-1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 _____ to 192 _____

that I last saw him alive on 192 _____

and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH * was as follows:

Premature Birth (4 Mo.)
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Signed) J. H. S. M. D.
4/10/1930 (Address) Gaithersburg Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Salisbury Cemetery 4-10-1930

20 UNDERTAKER ADDRESS

J. H. Johnson Damascus Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"),

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Pneumia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
MAY 8 1920
BUREAU

MARGIN RESERVED FOR BINDING

WRITE AGAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Poolesville (No. _____)

2 FULL NAME Arthur T. Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower
(Write the word)

6 DATE OF BIRTH Feb. 24, 1873
(Month) (Day) (Year)

7 AGE 57 yrs. 5 mos. 2 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Frederick Jones

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nettie Hempstone

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Chas. Elgin
(Address) Poolesville Md.

15 Filed July 25 1930 E. W. White Registrar

08160

(88)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 212

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 26, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from Sept 1925 to July 26, 1930
that I last saw him alive on July 26, 1930

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:
Coronary arteritis

(Duration) 4 yrs. 10 mos. ds.

Contributory Secondary Myocarditis
acute (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) E. W. White M. D.
July 26, 1930 (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Beallsville DATE OF BURIAL July 28, 1930

20 UNDERTAKER Hilton & Hall ADDRESS Poolesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 5 1930
BUREAU V. S.

NOTE--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		15155 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Dickerson</u>		St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>John Rufus Jones</u>		Registration Dist. No. <u>212</u>	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	
6 DATE OF BIRTH <u>Aug. 12, 1863</u> (Month) (Day) (Year)			
7 AGE <u>67</u> yrs. <u>4</u> mos. <u></u> ds. If LESS than 1 day ____ hrs. or ____ min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Thos. Jones</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Leana Beall</u>		
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lynwood Jones</u> (Address) <u>Poolsville</u>			
15 Filed <u>Dec 12 1930</u> <u>Wm. C. Hillon</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Dec. 12, 1930</u> <u>Dec</u> (Month) <u>11</u> (Day) <u>1930</u> (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec 11, 1930</u> to <u>Dec 12, 1930</u> , that I last saw him alive on <u>Dec 12, 1930</u> , and that death occurred on the date stated above, at <u>12.45 A.M.</u> The CAUSE OF DEATH * was as follows: <u>Organic Heart Disease</u> (Duration) ____ yrs. ____ mos. <u>10</u> ds. Contributory Secondary <u>Organic Perfor</u> (Duration) ____ yrs. ____ mos. <u>1</u> ds. (Signed) <u>E. W. White</u> M. D. <u>Dec 14, 1930</u> (Address) <u>Proctor</u>			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Beallsville Md</u>		DATE OF BURIAL <u>Dec 15, 1930</u>	
20 UNDERTAKER <u>Wm. T. Hillon</u>		ADDRESS <u>Beallsville</u>	

md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 5 1931
BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated ACTUALLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery Co

Village or City Rockville Wash. San An Hosp. St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby Karickhoff

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec. 18 1930
(Month) (Day) (Year)

7 AGE Stillborn If LESS than 1 day... hrs. yrs. mos. ds. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Montgomery Co Md.

10 NAME OF FATHER Lewis Shields Karickhoff

11 BIRTHPLACE OF FATHER (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Alice Virginia Snodgrass

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis S. Karickhoff

(Address) 112 Carroll Ave Takoma Park Md

15 Filed Dec 18 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 18 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from at delivery 192 to stillborn 192, that I last saw him/her on Jan at 6:57 P.M. and that death occurred on the date stated above, at — m.

The CAUSE OF DEATH * was as follows: asphyxiation from separation of placenta and cord around neck twice (Duration) yrs. mos. ds.

Contributory Fall of mother 3 wks before birth (Duration) yrs. mos. ds.

(Signed) Gene Lynn Buchheim M.D. Dec 18 1930 (Address) Wash. San An Hosp.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death Born at hospital in the State — yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence none

19 PLACE OF BURIAL OR REMOVAL cremated DATE OF BURIAL — 19—

20 UNDERTAKER Father ADDRESS —

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A third is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JAN 3 1911
BUREAU V.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

Village or City Spencerville (No.)

2 FULL NAME Seline Kelley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED mar
(Write the word)

6 DATE OF BIRTH Apr 24th 1867
(Month) (Day) (Year)

7 AGE 68 yrs. 9 mos. 3 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) home

9 BIRTHPLACE (State or country) Alexandria Va

10 NAME OF FATHER Robert Taylor

11 BIRTHPLACE OF FATHER (State or country) Via

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (State or country) Via

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nelson Kelley

(Address) P. O. Silver Spring Md

15 Filed Aug 20 1930 Ch Bannaday
Registrar

69384

(90)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 18th 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1st 1930 to Aug 18th 1930
that I last saw her alive on June 15th 1930

and that death occurred on the date stated above, at 9:30 P m.
The CAUSE OF DEATH * was as follows:

Myocarditis

(Duration) 9 yrs. 9 mos. ds.

Contributory Cardio Renal Disease
Secondary

(Duration) 4 yrs. mos. ds.

(Signed) Charles Simonsen M. D.
Aug 21 1930 (Address) Sandy Spring Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Spencerville Md Aug 21, 1930

20 UNDERTAKER ADDRESS

Leo R. Brondin Rockville Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

for issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the precise CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Typhoid* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOUR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 4 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Takoma Park (No. Wash. San + Hosp.)

2 FULL NAME William Kloyd - Kelly

15157 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Dec 24th, 1930
(Month) (Day) (Year)

7 AGE Stillborn If LESS than _____ yrs. _____ mos. _____ ds. or _____ min.

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Fred C Kelly

11 BIRTHPLACE OF FATHER (State or country) Michigan

12 MAIDEN NAME OF MOTHER Patrice Boswell

13 BIRTHPLACE OF MOTHER (State or Country) Mass

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed Dec 24 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 24th, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 24th 1930 to Dec 24th 1930, that I last saw him alive on Dec 24th 1930, and that death occurred on the date stated above, at 2:12 m.

The CAUSE OF DEATH * was as follows:

Asphyxia due probably to
anesthesia and instruments
delivery
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Signed) Layetta E. Bress M. D.
Dec 24th 1930 (Address) Takoma Park Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill, Cnty. Dec 24, 1930

20 UNDERTAKER

ADDRESS

Fred C. Kelly 4339 32nd St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (previously 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Senile," etc.), "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmaturia," "Marasmus," "Old Age," "Shock," "Insanition," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County MontgomeryVillage or City Silver Spring Gaithersburg, Md.2 FULL NAME Louis Christopher Kengla

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, single WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Dec. 10, 1868 1 (Month) (Day) (Year)

7 AGE 61 yrs. 5 mos. 18 ds. If LESS than 1 day..... hrs. or..... min.?

8 OCCUPATION (a) Trade, profession or particular kind of work butcher (b) General nature of industry business, or establishment in which employed or (employer).....

9 BIRTHPLACE (State or country) D. C.

10 NAME OF FATHER Wm. F. Kengla

11 BIRTHPLACE OF FATHER (State or country) D. C.

12 MAIDEN NAME OF MOTHER Helen R. Yeabower

13 BIRTHPLACE OF MOTHER (State or country) D. C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. D. Kengla(Address) Gaithersburg, Md.

15 Filed May 29, 1930 F. S. Dudley Registrar

05708

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28, 1930 192 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 27, 1930 192 to May 28, 1930 192

that I last saw him alive on May 27, 1930 192

and that death occurred on the date stated above, at 2:00 A. M.

The CAUSE OF DEATH * was as follows:

Cerebral Embolism(Duration)..... yrs..... mos..... ds. one ds.Contributory
Secondary

(Duration)..... yrs..... mos..... ds.

(Signed) F. J. Broschart M. D.
5/28/30 192 (Address) Gaithersburg, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL St John's Protestant Church DATE OF BURIAL 1930

20 UNDERTAKER Frank S. Sorenson Co ADDRESS 1113 - 74th St N.E. Washington, D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archibute, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement, never return "labore"; "Foreman," "Manager," "De-laborer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, House-work, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *typhoid fever* (never report "Typhoid Pneumonia"); *shot pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling tree—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

WRITE AGAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day.....hrs. yrs. mos. ds. or 0 min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Dec 22

1920

H. E. Rogers

Registrar

15158

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 25, 1920

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

12-25-1920 to 12-25-1920

that I last saw him alive on

and that death occurred on the date stated above, at 11 P. M. The CAUSE OF DEATH * was as follows:

Contributory Secondary

(Signed) M. D.

12-25-1920 (Address) Silver Spring, Md.

*State the Illness Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 51 Bryant St. Washington D.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cedar Hill

Dec 27, 1920

20 UNDERTAKER

ADDRESS

W W Chambers Co

1400 Chapin St NW

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

CERTIFICATE OF DEATH

Health Association.)

whatever, write *Nonc.*

Lobar pneumonia, Bronchopneumonia ("Pneumonia,"

American Medical Association.)

permanently filed.

JAN 3 1931

BUREAU

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Montgomery

Village or City

Montrose

(No.)

FULL NAME

Elizabeth Kueker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Oct 1

1849

(Month)

(Day)

(Year)

7 AGE

79 yrs.

9 mos.

10 ds.

If LESS than 1 day, hrs. min.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Pa.

10 NAME OF FATHER

John H. Sawatsky

11 BIRTHPLACE OF FATHER

(State or country)

Pa.

12 M maiden NAME OF MOTHER

Henrietta

13 BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Cyrus Kueker

(Address)

Rockville R # 3

15

Filed

July 21

1930

W. L. Lums

Registrar

08161

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 21, 1930

17

I HEREBY CERTIFY, That I attended the deceased from July 1, 1930, to July 21, 1930, that I last saw her alive on July 20, 1930, and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH * was as follows:

Acute Nephritis & uraemic poisoning

(Duration) 5 yrs. 10 mos. 10 ds.

Contributory Secondary

Acute scleritis

(Duration) 5 yrs. 10 mos. 10 ds.

(Signed) W. L. Lums M. D.

7-21 1930 (Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt Zion Church

July 23, 1930

20 UNDERTAKER

ADDRESS

W. L. Lums

Rockville

If more blanks are needed, address State Registrar, 13 W. Saratoga St., Balto., requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds., Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

1930
50
1850

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgo</u>		Registration Dist. No. <u>217</u>	
Village or City <u>Belney</u> (No. <u>Montgo</u> <u>Co</u> <u>3rd</u> <u>St</u> Ward)		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Living Keys</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>M</u>	4 COLOR OR RACE <u>Col</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>12 - 25 - 1908</u> (Month) (Day) (Year)			
7 AGE <u>21</u> yrs. <u>11</u> mos. <u>9</u> ds. or <u>LESS</u> than 1 day <u>hrs.</u> min.			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Shower</u> (b) General nature of industry business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <u>Mt.</u>			
PARENTS	10 NAME OF FATHER <u>John Keys</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Mt.</u>		
	12 MAIDEN NAME OF MOTHER <u>Winkley</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>—</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) <u>Chlor Keys</u>			
(Address) <u>Baltimore Md</u>			
15 Filed <u>Dec 18</u> 19 <u>30</u> <u>C. S. Barnsley</u> Registrar			
16 DATE OF DEATH <u>12/17/1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>12/15</u> 19 <u>30</u> to <u>12/17</u> 19 <u>30</u> , that I last saw him alive on <u>12/17/1930</u> , and that death occurred on the date stated above, at <u>12</u> m. The CAUSE OF DEATH * was as follows: <u>Chloris Indica</u> (Duration) <u>2</u> yrs. <u>—</u> mos. <u>—</u> ds. Contributory <u>Bum abcess</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>6</u> ds. (Signed) <u>John B. 33</u> M. D. (Address) <u>Sandy Spring</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>—</u> yrs. <u>—</u> mos. <u>3</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, if not at place of death? <u>—</u> Former or usual residence <u>—</u>			
19 PLACE OF BURIAL OR REMOVAL <u>Mt Zion</u>		DATE OF BURIAL <u>Dec 19, 1930</u>	
20 UNDERTAKER <u>Mr. Roy W. Barber</u>		ADDRESS <u>Laytonville</u>	

for issued If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by corbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 3 1931

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Belney

(No. _____)

2 FULL NAME

*Beatrice King*STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *217*

(If death occurred in hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

*Caucasian*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)*Married*

6 DATE OF BIRTH

*5-**4-**1872*

(Month)

(Day)

(Year)

7 AGE

*58 yrs.**6 mos.**19 ds.*If LESS than
1 day ____ hrs.
or ____ min.?

8 OCCUPATION

(a) Trade, profession or
particular kind of work*10th.*(b) General nature of industry
business, or establishment in
which employed or (employer)

9 BIRTHPLACE

(State or country)

*MD.*10 NAME OF
FATHER*Isaac Cepeland*11 BIRTHPLACE
OF FATHER
(State or country)*MD.*12 MAIDEN NAME
OF MOTHER*Amy Robinson*13 BIRTHPLACE
OF MOTHER
(State or country)*MD.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Temple H. Harris

(Address)

Baytonsville MD

15

Filed *Dec 24*, 19*20**C. S. Barnsley*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*12/23/**1920*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*12/20/**1920*

to

*12/23/**1920*that I last saw him alive on *12/23/*, 19*20*and that death occurred on the date stated above, at *3:15 P.M.*

The CAUSE OF DEATH * was as follows:

Coronary Arterio Sclerosis

(Duration)

yrs. *6*

mos.

ds.

Contributory
Secondary*Coronary Arterio Sclerosis*

(Duration)

yrs. *1*

mos.

ds.

(Signed)

KMB

M. D.

*12-23**1920*(Address) *Sandy Spring**State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs. *3*

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Brooke Grove,**12-26, 1920*

20 UNDERTAKER

ADDRESS

*Roy M. Barber**Baytonsville*

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Baito., Requesting V. S. No. 1.

for issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH, the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Typhoid* avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		04465		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Cabin John</u> (No.)		(46)		Registration Dist. No. <u>216</u>	
2 FULL NAME <u>Ida May King</u>		St.		Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>Dec. 7, 1876</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>Apr. 18, 1930</u> (Month) (Day) (Year)			
7 AGE <u>54 yrs. 4 mos. 11 ds.</u> If LESS than 1 day ____ hrs. or ____ min.?		17 I HEREBY CERTIFY That I attended the deceased from <u>Dec. 3, 1926</u> to <u>Apr. 18, 1930</u> that I last saw her alive on <u>Apr. 11, 1930</u> and that death occurred on the date stated above, at <u>8 p. m.</u> The CAUSE OF DEATH * was as follows:			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____		<u>Intestinal Carcinoma</u> (Duration) <u>3 yrs. 4 mos. 15 ds.</u>			
9 BIRTHPLACE (State or country) <u>md.</u>		Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.			
10 NAME OF FATHER <u>John E. Grimes</u>		(Signed) <u>Benny C. Berry</u> M. D. <u>4/19/30</u> (Address) <u>Berks Md.</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>md.</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
12 MAIDEN NAME OF MOTHER <u>Sarah Snowden</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____			
13 BIRTHPLACE OF MOTHER (State or Country) <u>md.</u>		19 PLACE OF BURIAL OR REMOVAL <u>Kemptown, Md.</u> DATE OF BURIAL <u>4/20, 1930</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>B. H. King</u> (Address) <u>Cabin John, Md.</u>		20 UNDERTAKER <u>J. B. Ball Inc</u> ADDRESS <u>Dumfries Md.</u>			
15 Filed <u>Apr. 19, 1930</u> <u>Benj. C. Berry</u> Registrar					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
MAY 5 1936
BUREAU

N. B. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

13917

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 21Village or City Laytonville (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John T. King

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH May 17, 1930
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day _____ hrs.
yrs. 5 mos. 25 ds. or _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Baby
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER John T. Smutte

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Margie M. King

13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margie M. King
(Address) Laytonville

15 Filed Nov 9, 1930 V. H. Dyeon
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 9, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 28, 1930 to Nov 9, 1930.

that I last saw him alive on Nov 13, 1930.

and that death occurred on the date stated above, at ? m.

The CAUSE OF DEATH * was as follows:

Broncho PneumoniaContributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) V. H. Dyeon M. D.Nov 9, 1930 (Address) Laytonville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Brook Grove Cemetery Nov 10, 1930

20 UNDERTAKER ADDRESS

Roy W. Barber Laytonville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

DEC 6 1930
BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County *Washington*

Village or City *Thetford* (No. *113*)

2 FULL NAME *Lawrence Joseph King*

10546 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. *214*

St. *Ward* (If death occurred in a hospital or institution, give its NAME, its street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*
4 COLOR OR RACE *W*
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Single*
6 DATE OF BIRTH *May 18 1930*
(Month) (Day) (Year)
7 AGE *3 18*
If LESS than 1 day ____ hrs. ____ yrs. ____ mos. ____ ds. or ____ min.?

OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) *D.C.*

10 NAME OF FATHER *Mr. King*

11 BIRTHPLACE OF FATHER (State or country) *Mr. King*

12 MAIDEN NAME OF MOTHER *Mr. King*

13 BIRTHPLACE OF MOTHER (State or Country) *"*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mr. Lawrence King*

(Address) *Thetford 131*

Filed *Sep 7 1930* *W. L. Lewis* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 6 1930*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from *Aug 31 1930* to *Sept 6 1930*

that I last saw him alive on *Sept 5 1930*

and that death occurred on the date stated above, at *Thetford*

The CAUSE OF DEATH was as follows:

*Acute Catarrhal
Nephritis*

Contributory
Secondary

(Signed) *Dr. J. W. King* M. D.
192__ (Address) *Thetford*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERLYING DISEASE

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

M. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH		STATE OF MARYLAND	
County <i>Montgomery</i>		CERTIFICATE OF DEATH	
Village <i>Colesville</i>		Registration Dist. No. <i>214</i>	
2 FULL NAME <i>Mary King</i>		If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <i>Female</i>	4 COLOR OR RACE <i>Colored</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <i>widowed</i> (Write the word)	
6 DATE OF BIRTH <i>August 14, 1844</i> (Month) (Day) (Year)			
7 AGE <i>86</i> yrs. <i>10</i> mos. <i>10</i> ds. or min. ?			
8 OCCUPATION (a) Trade, profession or particular kind of work. <i>None</i> (b) General nature of industry, business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <i>Bethesda Md.</i>			
PARENTS	10 NAME OF FATHER <i>Dennis Brown</i>		
	11 BIRTHPLACE OF FATHER (State or country) <i>Md.</i>		
	12 MAIDEN NAME OF MOTHER <i>Unknown</i>		
	13 BIRTHPLACE OF MOTHER (State or country) <i>Md.</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Sallie Wilson</i> (Address) <i>Silver Spring Md.</i>			
15 Filed <i>June 24 1930</i> <i>J. E. Dudley</i> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <i>June 24, 1930</i> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <i>after death</i> 192... that I last saw him alive on 192... and that death occurred on the date stated above, at <i>3:20 A.M.</i> The CAUSE OF DEATH was as follows: <i>Senile gangrene of right foot</i> (Duration) ... yrs. <i>4</i> mos. ... da. Contributory Secondary <i>Arteriosclerosis</i> (Duration) ... yrs. ... mos. ... da. (Signed) <i>William Bandhead</i> M.D. <i>June 24, 1930</i> (Address) <i>Silver Spring Md.</i> State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death ... yrs. ... mos. ... da. In the State, ... yrs. ... mos. ... da. Where was disease contracted, if not at place of death? Former or usual residence.			
19 PLACE OF BURIAL OR REMOVAL <i>Removal Washington D.C.</i>		DATE OF BURIAL <i>6/24, 1930</i>	
20 UNDERTAKER <i>W. E. Jarvis Co.</i>		ADDRESS <i>1432 You St.</i>	
If more blanks are needed, address State Registrar. 16 W. Saratoga St., Balto., Requester V. S. No. 1.			

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Retrolateral wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is to be read over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 10 1930

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			13918		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgomery</u>					Registration Dist. No. <u>211</u>	
Village or City <u>Clarksburg</u> No. _____			St. _____		Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mary Katherine King</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>				
6 DATE OF BIRTH <u>April 28, 1874</u> (Month) (Day) (Year)						
7 AGE <u>56</u> yrs. <u>5</u> mos. <u>8</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Fredricks Co. Md</u>						
PARENTS	10 NAME OF FATHER <u>Eduard. Ramshurg</u>					
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>					
	12 MAIDEN NAME OF MOTHER <u>Olhetta Hargett</u>					
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Fredricks Co. Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE						
(Informant) <u>Charles E. King</u>						
(Address) <u>Rt. 2 - Bayds Md</u>						
15 Filed <u>Nov 8th 1920</u> <u>William E. Lewis</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Nov 6th</u> 19 <u>20</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>March</u> 19 <u>20</u> to <u>Nov. 6th</u> 19 <u>20</u> , that I last saw her alive on <u>Nov. 4th</u> 19 <u>20</u> , and that death occurred on the date stated above, at _____ m.						
The CAUSE OF DEATH * was as follows: <u>Acute Coronary Thrombosis</u>						
(Duration) <u>10 min</u> yrs. mos. ds.						
Contributory Secondary <u>Arterial Sclerosis</u> <u>Cardiovascular disease</u>						
(Duration) <u>5</u> yrs. mos. ds.						
(Signed) <u>Walter S. Brown</u> M. D.						
(Address) <u>Danvers, Md</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)						
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.						
Where was disease contracted, if not at place of death? _____						
Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>St. Olivet Cemetery</u>						
DATE OF BURIAL <u>Nov 8th 1920</u>						
20 UNDERTAKER <u>Ernest Gartner</u>						
ADDRESS <u>Fatherbury Md</u>						

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1933

BUREAU V. S.

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1 PLACE OF DEATH
County Mont

Village or City Olney (No. _____)

2 FULL NAME (baby) King

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Aug 1, 1930
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. or _____ min.?
If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Frank King

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Lena Thomas

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lena King

(Address) Olney Md

15 Filed Aug 1, 1930 C. Barnard
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

09385

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

St. _____ Ward _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 1, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 1, 1930 to Aug 1, 1930
that I last saw her still on Aug 1, 1930

and that death occurred on the date stated above, at 1:30 P.M.
The CAUSE OF DEATH * was as follows:

Premature birth

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) O. C. Summleson M. D.
Aug 1, 1930 (Address) Bandy Spring

State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mr Sandy Spring Aug 1, 1930

20 UNDERTAKER ADDRESS

Frank King Olney Md.

per issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Imitation," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 4 1900
BUREAU U. S.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Montgomery

Village or City Takoma Park, Washington, D. C. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Kinsner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH July 10, 1867
(Month) (Day) (Year)

7 AGE 73 yrs. 0 mos. 14 ds. or min. If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Georgia

10 NAME OF FATHER Robt. Kinsner

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address)

15 Filed July 23, 1930 J. E. Dudley Registrar

08512

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 23, Wednesday, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 30, 1930 to July 23, 1930, that I last saw him alive on July 23, 1930, and that death occurred on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH was as follows:

Acute Parenchymatous Nephritis

Contributory Tuberculosis Kidneys
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) W. Kinsman M. D.

July 23, 1930 (Address) Takoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. 23 ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? W.

Former or usual residence Spring

19 PLACE OF BURIAL OR REMOVAL Rockville, Md. DATE OF BURIAL 7-25-1930

20 UNDERTAKER Harner & Humphrey Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro spinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

01815

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223Village or City Lakewood Park (No. 40)Sycamore Ave. Schomalk St. nd. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME LULU ECKBERT KISSINGER

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH <u>November 20</u> , 18 <u>60</u> (Month) (Day) (Year)
--

7 AGE <u>69</u> yrs. <u>3</u> mos. <u>ds.</u> or <u>min.</u>	If LESS than 1 day <u>hrs.</u> or <u>min.</u>
---	---

8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer)
--

9 BIRTHPLACE (State or country) <u>Selins Grove, Pa.</u>
--

10 NAME OF FATHER <u>Wm. Fox</u>

11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>

12 MAIDEN NAME OF MOTHER <u>Anna Davis</u>

13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. Kissinger(Address) 40 Sycamore Ave.

15 Filed <u>Feb. 4</u> 19 <u>30</u> <u>H. E. Rogers</u> Registrar
--

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>February 4</u> , 19 <u>30</u> (Month) (Day) (Year)
--

17 I HEREBY CERTIFY, that I attended the deceased from
January 21, 1930 to Feb. 2, 1930.

that I last saw her alive on Feb. 2, 1930.and that death occurred on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH * was as follows:

Acute cardiac dilatationContributory
Secondary(Duration) 10 yrs. 3 mos. ds.(Signed) Wm. A. Shannon M. D.February 4, 1930. (Address) 113-C Canal St. Schomalk D. C.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 10 yrs. 3 mos. ds. In the State 10 yrs. 3 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL <u>Washington, D. C.</u>	DATE OF BURIAL <u>Feb. 7</u> , 19 <u>30</u>
---	--

20 UNDERTAKER <u>S. Hines Co.</u>	ADDRESS <u>2901-14 Ave</u>
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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archibed, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Teacher," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *typhoid fever* (never report "Typhoid Pneumonia"); *short pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc.*; of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate be permanently filed.

MAR 4 1930
BUREAU OF VITAL STATISTICS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		05709 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Takoma Park</u> (No. <u>804 Floral Ave</u>)		Registration Dist. No. <u>223</u>	
2 FULL NAME <u>Isaac N Knapp</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>	
6 DATE OF BIRTH <u>Jan 6 1851</u> (Month) (Day) (Year)			
7 AGE <u>79 yrs. 4 mos. 19 ds.</u> If LESS than 1 day... hrs. or... min.?			
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry business, or establishment in which employed or (employer)			
9 BIRTHPLACE (State or country) <u>Conn.</u>			
PARENTS	10 NAME OF FATHER <u>Isaac Knapp</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Conn.</u>		
	12 MAIDEN NAME OF MOTHER <u>Theodora Mead</u>		
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Conn.</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Anna Knapp</u> (Address) <u>504 - Aspen Ln. Ch.</u>			
15 Filed <u>May 25 1930</u> <u>H. E. Rogers</u> Registrar			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>May 25 1930</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended the deceased from <u>May 16 1930</u> to <u>May 25 1930</u> , that I last saw him alive on <u>May 24 1930</u> , and that death occurred on the date stated above, at <u>m.</u> The CAUSE OF DEATH* was as follows: <u>Arterio-sclerosis</u> <u>myocarditis</u> <u>Indefinite</u> (Duration) yrs. mos. ds.			
Contributory Secondary (Duration) yrs. mos. ds.			
(Signed) <u>W. S. Heale</u> M. D. <u>May 25 1930</u> (Address) <u>6511 S. 7th St.</u>			
*State the Disease Causing Death, or, in case of Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.			
Where was disease contracted, if not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Wash. D.C.</u>		DATE OF BURIAL <u>May 25 1930</u>	
20 UNDERTAKER <u>The S. H. Jones Co</u>		ADDRESS <u>Wash. D.C.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report, specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JUN 4 1930

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Bethesda (No. _____)

2 FULL NAME Mrs. Edith C. Reister

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Jan 15, 1888
(Month) (Day) (Year)

7 AGE 42 yrs. 11 mos. 15 ds. or _____ min. 2
If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) D.C.

10 NAME OF FATHER James D. Law

11 BIRTHPLACE OF FATHER (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Gettier Gekette

13 BIRTHPLACE OF MOTHER (State or Country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. John Reister

(Address) 207 Irvington Dr. N.E.

15 Filed Jan 16 1930 Benj. O. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 15, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 30, 1924 to Jan 15, 1930, that I last saw him alive on Jan 13, 1930.

and that death occurred on the date stated above, at 3 AM m.

The CAUSE OF DEATH * was as follows:

Indurated carcinoma of breast.

(Duration) 1 yrs. 8 mos. 15 ds.

Contributory Secondary Asbestosis, Emphysema

(Duration) 3 yrs. 3 mos. 3 ds.

(Signed) W. C. Cunningham M. D.

1-15-30 1924 (Address) 1726 M St. N.E.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Bethesda Md.

DATE OF BURIAL

1/17, 1930

20 UNDERTAKER

H. C. Humphrey

ADDRESS

Lackville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1918

BOR

WRITE BLOOD WITH UNFADING INK---THIS IS A PERMANENT RECORD

N B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Montgomery

04466

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City

Takoma Park

(No. 228

Maple Ave.

St.:

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

JAMES RALPH KYLE

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

February 16, 1906
(Month) (Day) (Year)

7 AGE

24 yrs. 2 mos. ds. or min.?

If LESS than
1 day... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Government Clerk

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Washington D.C.

10 NAME OF FATHER

Samuel Ralph Kyle

11 BIRTHPLACE OF FATHER

(State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Joana B. Nickalls

13 BIRTHPLACE OF MOTHER

(State or country)

Washington D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Samuel R. Kyle

(Address)

228 Maple Ave. Takoma Park, Md.

15

Filed

April 7, 1930 H. E. Rogers

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 6, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192... to April 6, 1930.

that I last saw him alive on... 192...

and that death occurred on the date stated above, at... m.

The CAUSE OF DEATH * was as follows:

Asphyxiation
Deceased found dead in room with gas turned on, a note beside him explaining that it was suicide.

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

W. M. A. Shannon M.D.
April 7, 1930 (Address) Takoma Park, D.C.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D.C. April 8, 1930

20 UNDERTAKER

ADDRESS

Almus H. Speare 1623 Conn Ave

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

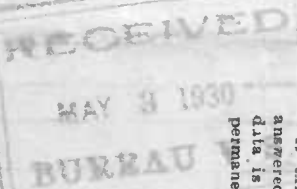
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (c) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. As the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		08519		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>MD</u>		(157-4)		Registration Dist. No. <u>214</u>	
Village or City <u>Beltsville</u> (No. <u>157-4</u>)		St. <u></u> Ward <u></u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Louise Lancaster</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>July 23, 1930</u> (Month) (Day) (Year)					
7 AGE <u>5</u> yrs. <u>5</u> mos. <u>5</u> ds. or <u>1</u> day <u>1</u> hrs. <u>1</u> min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry business, or establishment in which employed or (employer) <u></u>					
9 BIRTHPLACE (State or country) <u>MD</u>					
PARENTS	10 NAME OF FATHER <u>Raymond Lancaster</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>MD</u>				
	12 MAIDEN NAME OF MOTHER <u>Ruth Jackson</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>MD</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Raymond Lancaster</u> (Address) <u>Beltsville MD</u>					
15 Filed <u>July 28, 1930</u> T. E. Shulding Jr. Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 28, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>July 27, 1930</u> to <u>July 28, 1930</u> that I last saw her alive on <u>July 27, 1930</u> and that death occurred on the date stated above, at <u>6 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Acute Dilatation of heart</u> (Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. Contributory <u>Patent Heart Valve</u> Secondary <u>6</u> ds. (Signed) <u>Dr. B. Haynes</u> M. D. <u>July 28, 1930</u> (Address) <u>Beltsville MD</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. In the State <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds. Where was disease contracted, if not at place of death? <u></u> Former or usual residence <u></u>					
19 PLACE OF BURIAL OR REMOVAL <u>On Premises</u>				DATE OF BURIAL <u>July 28, 1930</u>	
20 UNDERTAKER <u>Self</u>				ADDRESS <u></u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 9 1936
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mt.

Village or City Beltville (No. _____)

2 FULL NAME No name Lancaster

08518

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 23, 1930
(Month) (Day) (Year)

7 AGE Still born IF LESS than 1 day ____ hrs. 2 yrs. ____ mos. ____ ds. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Mt. Co.

10 NAME OF FATHER Raymond Lancaster

11 BIRTHPLACE OF FATHER (State or country) Beltville, Mt.

12 MAIDEN NAME OF MOTHER Ruth Jackson

13 BIRTHPLACE OF MOTHER (State or Country) Beltville Mt. Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Raymond Lancaster
(Address) Beltville, Md.

15 Filed July 23 1930 J. S. Bludwig Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 23, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 ____ to 192 ____.

that I last saw him alive on 192 ____.

and that death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH * was as follows:

Still born
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. R. Harner M. D.
July 23, 1930 (Address) Bellevue Springs, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Own yard DATE OF BURIAL July 23, 1930

20 UNDERTAKER Self ADDRESS Beltville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmaturia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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SEP 8 1930
BUREAU V. S.

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1 PLACE OF DEATH

County

Montgomery

08162

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City

Takoma Park (No. 204 Willow Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Margaret L. Lawry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

May 30, 1850
(Month) (Day) (Year)

7 AGE

80 yrs. 1 mos. 9 ds. or min.?

If LESS than
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Canada

10 NAME OF FATHER

Humble

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clarence Lawry

(Address)

213 - Cedar Ave. Takoma Park, Md.

15 Filed

July 11, 1930 H. B. Revis

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 9, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to July 9th, 1930

that I last saw him alive on July 9th, 1930

and that death occurred on the date stated above, at 5:50 p.m.
The CAUSE OF DEATH * was as follows:Chronic Myocarditis
(Duration) 10 yrs. mos. ds.Contributory
Secondary(Signed) Donald E. Greenberg M. D.
7/9/30 (Address) Takoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 8 yrs. mos. ds. In the State 8 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Washington D.C.

DATE OF BURIAL

July 11, 1930

20 UNDERTAKER

H. B. Revis

ADDRESS

924 N. 3 Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *sc. shoptumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 5 1930
BUREAU

MARGIN RESERVED FOR BINDING

WRITE

AIN

WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Mont

Village or City Norbeck - or Rockville R 2 D (No. 11-a)

2 FULL NAME Alice Lorraine Lee

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH July 26th, 1930
(Month) (Day) (Year)

7 AGE — yrs. 4 mos. 19 ds. or — min. If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) D.C.

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER Elizabeth Lee

13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elizabeth Lee
(Address) Rockville R 2 D

15 Filed Dec 15 1930 C. S. Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 14th, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 14th 1930 to Dec 14th 1930, that I last saw him alive on Dec 14th 1930,

and that death occurred on the date stated above, at 5¹⁰ m. The CAUSE OF DEATH * was as follows:

Pneumonia

(Duration) _____ yrs. _____ mos. 3 ds.

Contributory Secondary Influenza

(Duration) _____ yrs. _____ mos. 3 ds.

(Signed) Olaf Gunnarsson M. D.
Dec 15th 1930 (Address) Sandy Spring Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Norbeck Cem. DATE OF BURIAL Dec 16 1930

20 UNDERTAKER Geo Snowden ADDRESS Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

per issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Solemnion, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Scrofula, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Alney

(No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Leola A. See.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

2 - 16, 1890

(Month)

(Day)

(Year)

7 AGE

40 yrs. 0 mos. 9 ds.

If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Student

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

James See.

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Sarah Robinson

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah See.

(Address)

Stylonsville

15

Filed *Feb 28, 1930* *C. S. Barnsby*

Registrar

per issued

01816

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *217*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

2/25, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

*2/11, 1930 to 2/25, 1930*that I last saw him alive on *2/25, 1930*and that death occurred on the date stated above, at *10 P.* m.

The CAUSE OF DEATH * was as follows:

Carcinoma of Stomach(Duration) *9* yrs. *0* mos. *0* ds.Contributory
Secondary(Duration) *0* yrs. *0* mos. *0* ds.

(Signed)

Leola A. See.

M. D.

2/28, 1930 (Address) *Sandy Spring*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death *0* yrs. *0* mos. *0* ds.In the State *0* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Oak Grove**2-28, 1930*

20 UNDERTAKER

ADDRESS

*Roy Barber**Laytonsville*

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

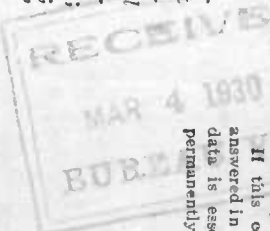
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (c) Salesman, (b) Grocer; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At School, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory
Secondary

(Signed)

M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic tubular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
AUG 14 1914
BUREAU

Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

Country

Village or City

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 211

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than
1 day 7 hrs.
yrs. mos. ds. or min.?

OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country)10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Sept 5 1930

Della K. Beall

Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory
Secondary

(Signed) M. H. Masterson M. D.

Sept 3 1930 (Address) Lorton Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 6 1930

BUREAU OF

MARGIN RESERVED FOR BINDING

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Claggettville

2 FULL NAME Watt Lacy Lee Jr.

10548

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 211

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) MARRIED

6 DATE OF BIRTH Sept 2 1930
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day _____ hrs. _____ yrs. _____ mos. _____ ds. or _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Claggettville

10 NAME OF FATHER Watt Lee

11 BIRTHPLACE OF FATHER (State or country) Howard Co

12 MAIDEN NAME OF MOTHER Vallae Biggus

13 BIRTHPLACE OF MOTHER (State or Country) Montgomery Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Watt Lee
(Address) Woodbine Ind

15 Filed Sept. 3 1930 W. B. Beall
Registral

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 24 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 1930 to Sept 24 1930, that I last saw him alive on Sept 24 1930 and that death occurred on the date stated above, at 6 m. The CAUSE OF DEATH * was as follows:

Premature
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. H. Master M. D. Sept 3 1930 (Address) Luskon Ind

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Poplar DATE OF BURIAL Sept 4 1930

20 UNDERTAKER J. B. Beall Inc ADDRESS Damascus, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer retired 6 yrs*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid, Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

OCT 6 1930

BUREAU V. 8

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

2 FULL NAME

01817

(90)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than 1 day 1 hrs. 1 day 1 mos. 1 yr. 1 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from 1923 to 1923, that I last saw him alive on 1923, and that death occurred on the date stated above, at 7:40 PM.

The CAUSE OF DEATH * was as follows:

Contributory Secondary

*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR CREMATION

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonæum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 5 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Mtg

09386

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

214

Village or City

Silver Spring

(No.)

Maplewood San.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Miss Emma Levi

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Jan ?

(Month)

(Day)

1858

(Year)

7 AGE

72 yrs.

0 mos.

? ds.

If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Wash. D.C.

10 NAME OF FATHER

John Levi

11 BIRTHPLACE OF FATHER

(State or country)

Wash. D.C.

12 MAIDEN NAME OF MOTHER

Catherine Jones

13 BIRTHPLACE OF MOTHER

(State or Country)

DC.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Lucian Hawland

(Address)

Silver Spring, Md.

15

Filed

Aug 24

1930

J. S. Dudley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 24, 1930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Aug. 23, 1930. to Aug. 24, 1930.

that I last saw him alive on Aug. 23, 1930.

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH * was as follows:

Myocarditis

(Duration) 10 yrs. 0 mos. 0 ds.

Contributory Secondary

Acute Nephritis

(Duration) yrs. mos. 3 ds.

(Signed)

W. R. Haynes, M. D.

Aug 24, 1930 (Address) Silver Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 9 yrs. 6 mos. 23 ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

DC.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington DC

Aug 24, 1930

20 UNDERTAKER

ADDRESS

Frank Leiers Sons Co

1113-7 New

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Montg.

09387

(89)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

Village or City

Cherry Chase

(No. 22)

Brafton

St.

Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME WASHINGTON BARTLETT LEWIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)

married

6 DATE OF BIRTH

March

28

1884

(Month)

(Day)

(Year)

7 AGE

46 yrs.

1 mos.

18 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Art. Director

(b) General nature of industry, business, or establishment in which employed (or employer)

National Parks Dept. of Interior

9 BIRTHPLACE

(State or country)

Michigan

PARENTS

10 NAME OF FATHER

Bartlett Lewis

11 BIRTHPLACE OF FATHER

(State or country)

Michigan

12 MAIDEN NAME OF MOTHER

Lothian

13 BIRTHPLACE OF MOTHER

(State or country)

Canada

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bernie Barde Lewis

(Address)

22 Brafton St.

15

Filed

8-27-

1930

Thomasklonas

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

August 26

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 15, 1930, to August 26, 1930.

that I last saw him alive on August 25, 1930.

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 4 yrs. 2 mos. ds.

Contributory
Secondary

myocarditis

(Duration) 10 yrs. mos. ds.

(Signed) Wm. F. Beer dieck, M. D.

Aug 27, 1930 (Address) 3725 Jennifer St. S.C.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Lincoln Cemetery 8/28, 1930.

20 UNDERTAKER

J. S. Cantersous

ADDRESS—R. Mc. Wash, S.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

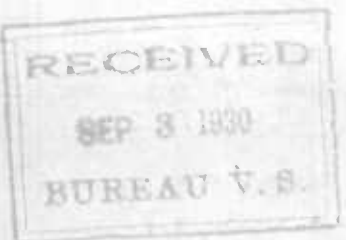
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-feutal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE AINL WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Montgomery</u>		08163		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Bethesda</u> (No. <u>6951</u>)		St. <u>W. Ave.</u>		Registration Dist. No. <u>216</u>	
2 FULL NAME <u>Emma Lloyd</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Child</u> (Write the word)			
6 DATE OF BIRTH <u>July 20</u> , 19 <u>30</u> (Month) (Day) (Year)					
7 AGE <u>(Stillbirth)</u> If LESS than 1 day — hrs. — or — min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>none</u>					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
10 NAME OF FATHER <u>Adam C. Lloyd</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Florida</u>					
12 MAIDEN NAME OF MOTHER <u>Lotty Holmschein</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Germany</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address) <u>Benj. C. Perry</u> Registrar					
15 Filed <u>7/21</u> 19 <u>30</u>					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 20</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>July 20</u> , 19 <u>30</u> to <u>July 20</u> , 19 <u>30</u> , that I last saw her <u>alive</u> on <u>July 20</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>11 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Stillbirth</u> (Duration) — yrs. — mos. — ds.					
Contributory Secondary (Signed) <u>Wheeler</u> M. D. <u>July 20</u> , 19 <u>30</u> (Address) <u>Bethesda, Md.</u> State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Bethesda, Md.</u>				DATE OF BURIAL <u>7/21</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Holmschein, M. H.</u>				ADDRESS <u>Bethesda.</u>	

If more banks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Remover wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Montgomery

Village or City Cherry Chase (No. _____) St. _____ Ward _____

2 FULL NAME Francis Bryan Lightbown

01818

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Oct. 29, 1915
(Month) (Day) (Year)

7 AGE 14 yrs. 3 mos. 28 ds. or min. If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER C. M. Lightbown

11 BIRTHPLACE OF FATHER (State or country) DC

12 MAIDEN NAME OF MOTHER Maud E. Lightbown

13 BIRTHPLACE OF MOTHER (State or Country) DC

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. M. Lightbown

(Address) #5 Thasall St Cherry Chase

15 Filed 2/27 19230 Benj. C. Perry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH February 26, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 26, 1930 to Feb. 26, 1930

that I last saw him alive on _____, 192____,

and that death occurred on the date stated above, at 11 A. m.

The CAUSE OF DEATH * was as follows:

Dead when seen

Acute dilation of heart
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Signed) Benj. C. Perry, M.D. M. D.
Feb. 26, 1930 (Address) Bethesda, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Washington DC DATE OF BURIAL Feb. 28, 1930

20 UNDERTAKER F. Gasch Louis ADDRESS Hyattsville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

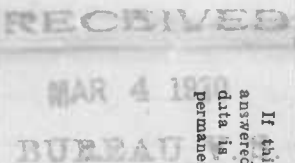
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE MAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Mr. Etchison (No. _____) St. _____ Ward _____

2 FULL NAME Mrs. Genevieve Lincoln

12877 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE C. 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH August 27 1925
(Month) (Day) Year

7 AGE 5 yrs. 1 mos. 12 ds. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Unknown to me

11 BIRTHPLACE OF FATHER (State or country) "

12 MAIDEN NAME OF MOTHER Louise Lincoln

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louise Lincoln

(Address) R. D. Gaithersburg Md.

15 Filed Oct. 11 1930 V. S. No. 1
Defy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 22 Oct. 9 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept. 22 1930 to Oct. 9 1930, that I last saw her alive on Oct. 8 1930

and that death occurred on the date stated above, at 5 a m.

The CAUSE OF DEATH was as follows:

Encephalitis
"Sleeping sickness" culture

(Duration) _____ yrs. _____ mos. 20 ds.

Contributory Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) George M. Boyer M. D.

Oct. 9 1930 (Address) Damascus, Md.

State the Cause Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Brook Grove Cem. Md. Oct. 11 1930

Ms. Montgomery, Md. ADDRESS

Row H. Barber Baytownville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Commissioner, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia ("Pneumonia,*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death, 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 6 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Montgomery

Village or City Ednor (No. _____)

² FULL NAME Sarah E. Link

12556

(129)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH May 17th 1851
(Month) (Day) (Year)

7 AGE 79 yrs. 5 mos. 10 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) General Household

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER William F. Nelson

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER M. Elizabeth Harding

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Link

(Address) _____

15 Filed Oct 28 1930 C. S. Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 27th 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept. 16th 1930 to Oct. 27th 1930, that I last saw her alive on Oct. 27th 1930, and that death occurred on the date stated above, at 12¹⁵ P. M.

The CAUSE OF DEATH * was as follows:

Arterial Sclerosis & Hypertension

(Duration) 5 yrs. 7 mos. ds.
Contributory Chronic Nephritis
Secondary (Duration) 2 yrs. 7 mos. ds.

(Signed) M. W. L. Cusill M. D.
Oct. 27 1930 (Address) Highland, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Burtonsville

DATE OF BURIAL

Oct 29, 1930

20 UNDERTAKER

Kaiser

ADDRESS

Laurel, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

for issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mescal*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mescal* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*, *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, (manus)* may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

At this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 4 1930

BUREAU V. S.

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		12557		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Silver Spring</u> (No. _____)		St. _____		Registration Dist. No. <u>214</u>	
2 FULL NAME <u>James Nathaniel Sinkins</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>			
6 DATE OF BIRTH <u>Unknown</u> 18 <u>57</u> (Month) (Day) (Year)					
7 AGE <u>73</u> yrs. ____ mos. ____ ds. or LESS than 1 day ____ hrs. ____ min.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Plasterer</u> (b) General nature of industry business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>District of Columbia</u>					
10 NAME OF FATHER <u>Joseph C. Sinkins</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>					
12 MAIDEN NAME OF MOTHER <u>Dusan Coxen</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>Unknown</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. S. S. Nutting</u> (Address) <u>1351 Newton St. N.W.</u> <u>Washington D.C.</u>					
15 Filed <u>Oct 28 1930</u> <u>T. E. Dudley</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>October 27</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> that I last saw him alive on <u>192</u>					
and that death occurred on the date stated above, at <u>about 4 P.M.</u> The CAUSE OF DEATH * was as follows: <u>Died suddenly while sitting in chair and without medical attendance.</u> <u>Probably heart disease.</u> (Duration) ____ yrs. ____ mos. ____ ds.					
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.					
(Signed) <u>J. J. Threlkett</u> M. D. <u>Oct 27 1930</u> (Address) <u>928 Wisconsin St. Silver Spring, Md.</u>					
*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Rock Creek Cemetery</u>				DATE OF BURIAL <u>Oct 29 1930</u>	
20 UNDERTAKER <u>W. R. Humphrey</u>				ADDRESS <u>Rockville</u>	

Dr Howard Stans Att
Lillian Spring Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

NOV 7 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, paralysis*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

MARGIN RESERVED FOR BINDING

WRITE MAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

05710

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Alney Montgomery St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Shirley Ann Taylor Lucas

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE N 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) ---

6 DATE OF BIRTH 5/31, 1930
(Month) (Day) (Year)

7 AGE --- If LESS than 1 day --- hrs. --- yrs. --- mos. --- ds. or --- min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work ---
(b) General nature of industry, business, or establishment in which employed or (employer) ---

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Geo Lucas

11 BIRTHPLACE OF FATHER (State or country) MD.

12 MAIDEN NAME OF MOTHER Elizabeth May Johnson

13 BIRTHPLACE OF MOTHER (State or country) MD.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother

(Address) ---

15 Filed May 4 1930 C. S. Barnsley
Registrar

for issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5/31, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at --- m.

The CAUSE OF DEATH * was as follows:

Still born, full term due to premature separation of placenta
(Duration) --- yrs. 1 mos. --- ds.

Contributory Uterine 5/31/30
Secondary

(Duration) --- yrs. --- mos. --- ds.

(Signed) J. M. S. M. D.

5/4 1930 (Address) Sandy Spring

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death --- yrs. --- mos. --- ds. In the State --- yrs. --- mos. --- ds.

Where was disease contracted, if not at place of death? ---

Former or usual residence ---

19 PLACE OF BURIAL OR REMOVAL Rockville DATE OF BURIAL May 5, 1930

20 UNDERTAKER W. R. Humphrey, Jr. ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 4 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Ashton, Md.2 FULL NAME Mary W. Luckett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH July 7, 1848
(Month) (Day) (Year)7 AGE 82 yrs. 4 mos. 1 ds. or LESS than 1 day ____ hrs. ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Washington, D.C.10 NAME OF FATHER Zachariah Johnston11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Anna Holland13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Alexander Kilgus(Address) Rockville, Md.15 Filed Nov 9, 1930 C. S. Barnsley
Registrarfor issued.

13919

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217

(129)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 8th, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from July 1, 1930 to Nov 8th, 1930
that I last saw him alive on Nov 3, 1930and that death occurred on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH * was as follows:

Arteriosclerosis and Chronic Nephritis
(Duration) unknown yrs. ____ mos. ____ ds.Contributory
Secondary _____(Signed) Charles Campbellson M. D.
Nov 8th, 1930 (Address) Land Spring Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Union Cemetery, Rockville DATE OF BURIAL Nov. 11, 193020 UNDERTAKER Warner E. Humphrey ADDRESS Rockville, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

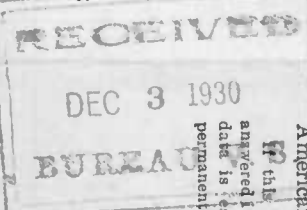
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

08164

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 212

Village or City Sellman (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sarah Elizabeth Fisher

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July - 23 - 1858
(Month) (Day) (Year)

7 AGE 71 - yrs. 11 mos. 16 ds. or min. If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER William A. Price

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Rebecca Webster

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur P. Fisher
(Address) Sellman, Md.

15 Filed July 10 1930 Mrs. C. C. Hill Registrar Curran

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July - 9 - 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June - 17 - 1930 to July - 9 - 1930
that I last saw him alive on July - 9 - 1930

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH * was as follows:
Myocardial degeneration

Contributory Cerebral hemorrhage
Secondary (Duration) 2 yrs. 2 mos. 2 ds.

(Signed) W. C. Gutter M. D.
7-10-1930 (Address) Frederick, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Bucksburg Cemetery DATE OF BURIAL 7-12-1930

20 UNDERTAKER Wm. H. Fisher Sons ADDRESS Baltimore

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia," "Lobar pneumonia, Bronchopneumonia ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, "Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A. The data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
AUG 5 1900
BUREAU

WRITE MAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Montgomery

Village or City Rockville (No. 129) Maryland St. Ward

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Charles James Lydaone

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH June 28 1854
(Month) (Day) (Year)

7 AGE 75 yrs. 7 mos. 28 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed or (employer) Retired

9 BIRTHPLACE (State or country) Rockville Montgo Co Md

10 NAME OF FATHER Thomas Lydaone

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER Margaret Jones

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. T. Brett
(Address) 505 Southbrook Ct. Rockville

15 Filed 2-28 1930 W. T. Brett
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 24 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 3 1926 to Feb 24 1930
that I last saw him alive on Feb 24 1930

and that death occurred on the date stated above, at 3 P m.

The CAUSE OF DEATH * was as follows:
Chronic Nephritis

Contributory Secondary Chronic Myocarditis
(Duration) 4 yrs. mos. ds.

(Signed) C. J. Hawpo M. D.
192 (Address) Rockville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rockville Union Cemetery DATE OF BURIAL Feb. 28 1930

20 UNDERTAKER Almus R. Speare ADDRESS 4512 Ridge St. Chevy Chase, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
MAR 8 1920
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County Montgomery05711 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213Village or City Scotland (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Isaiah Syles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
-------------------	-----------------------------------	--

6 DATE OF BIRTH _____
(Month) 1 (Day) _____ (Year) _____7 AGE 61 yrs. _____ mos. _____ ds. or _____ min.?
If LESS than 1 day _____ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country)

10 NAME OF FATHER Montford Mnd11 BIRTHPLACE OF FATHER James Syles
(State or country) Mnd12 MAIDEN NAME OF MOTHER Sarah Jackson13 BIRTHPLACE OF MOTHER Mnd
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Dove(Address) Scotland Mnd15 Filed 5-25 1940 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 21, 1940
(Month) _____ (Day) _____ (Year) _____17 I HEREBY CERTIFY, That I attended the deceased from January 1927 to March, 1940
that I last saw him alive on March 15, 1940

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

myocarditis

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Secondary arterio-sclerosis

(Signed) J. V. Hartley M. D.
May 22, 1940 (Address) Rockhill

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Scotland Mnd May 14, 1940

20 UNDERTAKER

ADDRESS

Geo R. Brundage Rockhill
Mnd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUN 10 1930

N. B.--Every item of information should be carefully supplied. ACE should be stated ACTUALLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

04468

(161-C)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223

Village or City

Takoma Park (No. Washington Sanatorium St. Washington Ward and Hospital Takoma Park, Md)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Maddox, Dorothy Louise

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write this word)single

6 DATE OF BIRTH

April 9, 1930
(Month) (Day) (Year)

7 AGE

8 yrs. 8 mos. 8 da. or min.
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

none9 BIRTHPLACE
(State or country)Montgomery Co. Md.10 NAME OF
FATHERMaddox, John B.11 BIRTHPLACE
OF FATHER
(State or country)Washington D.C.12 MAIDEN NAME
OF MOTHERJames, Nellie L.13 BIRTHPLACE
OF MOTHER
(State or country)Washington D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. Mitchell

(Address)

Silver Spring, Md.

15

Filed April 16 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 16, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from April 9, 1930 to April 16, 1930, that I last saw him alive on April 15, 1930, and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH * was as follows:

Cerebral hemorrhage(Duration) yrs. 8 mos. 8 ds.Contributory
SecondaryConvulsions - Cerebral(Duration) yrs. 8 mos. 8 ds.

(Signed)

W. Mitchell M. D.
April 16, 1930 (Address) Silver Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 8 mos. 8 ds. In the State yrs. 8 mos. 8 ds.Where was disease contracted, if not at place of death? Place of deathFormer or usual residence Parents Residence, Silver Spring, Md.

19 PLACE OF BURIAL OR REMOVAL

Int. Olivet

DATE OF BURIAL

4/16, 1930

20 UNDERTAKER

W. W. Deal Co.

ADDRESS

816 H. 2-2

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 8 1930

BUREAU V. 9

MARGIN RESERVED FOR BINDING

WRITE MAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1 PLACE OF DEATH
County Montgomery

09389
(90)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2 L3

Village or City Hunting Hill (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Juliette Stella Magruder

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May 4 1898
(Month) (Day) (Year)

7 AGE 82 yrs. 3 mos. 27 ds. or min.? If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Abraice Nixon Newman

11 BIRTHPLACE OF FATHER (State or country) va

12 MAIDEN NAME OF MOTHER Willie Anne Kereford

13 BIRTHPLACE OF MOTHER (State or country) va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Elmer Magruder
(Address) P.O. Rockville Md

15 Filed 8/2 1930 after Dr. Bourne Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 1st 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov. 10th to Aug 1st 1930, that I last saw her alive on Aug 1st 1930, and that death occurred on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH * was as follows:
Myocarditis
Aortic Stenosis
(Duration) 1 yrs. 0 mos. 0 ds.
Contributory Fascial infection
Secondary (Duration) 10 yrs. 0 mos. 10 ds.

(Signed) Upton D. Brown M. D.
8/2 1930 (Address) Danversville Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville Md DATE OF BURIAL Aug 8 1930

20 UNDERTAKER Warner Pumphrey ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of use of "Tumor" for malignant neoplasms); *Mucositis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucositis* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WHEN PREPARED WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Silver Spring

(No.)

Maplewood Sanitarium

Ward)

2 FULL NAME

Michael Maguire

13920

(74a)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

214

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Oct 17, 1859

7 AGE

71 yrs. 18 ds.

If LESS than 1 day, hrs. OR min. ?

OCCUPATION (a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Railroad

9 BIRTHPLACE (State or country)

D.C.

PARENTS

10 NAME OF FATHER

John Maguire

11 BIRTHPLACE OF FATHER (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Anne Mc Guillian

13 BIRTHPLACE OF MOTHER (State or country)

Ireland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

B. F. Schrader

(Address)

6915-6 NW

15

Filed Nov. 5, 1930 J. E. Dwyer

REG. STRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

NOVEMBER 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from

October 17, 1930, to November 4, 1930,

that I last saw him alive on November 4, 1930,

and that death occurred on the date stated above, at 11:30 pm.

The CAUSE OF DEATH * was as follows:

Semicardiac dilatation

Contributory Secondary

Cerebral Hemorrhage

(Signed)

W. M. A. Shannon

Nov. 5, 1930, (Address) 113-Canall St. N. E.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 2 mos. 15 ds. In the State, yrs. mos. ds.

Where was disease contracted, Washington D.C.

If not at place of death?

Former or usual residence 6915-6th St. N.W. Wash. D.C.

19 PLACE OF BURIAL OR REMOVAL

Washington D.C.

DATE OF BURIAL

Nov. 5, 1930

20 UNDERTAKER

Frank Leiers Sons Co 1113-7 NW

ADDRESS

Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melancholia*, *Wandering*; *Chronic valvular heart disease*; *Acute interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *letanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
DEC 8 1930
BUREAU V

1 PLACE OF DEATH

County Montgomery15162 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223Village or City Takoma Park, Md.Washington San. & Hosp. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Grace Marlow

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH Jan. 24, 1875
(Month) (Day) (Year)7 AGE 55 yrs. 10 mos. 22 ds. If LESS than 1 day ____ hrs. or ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Md.10 NAME OF FATHER Mr. W. Hester11 BIRTHPLACE OF FATHER (State or country) Tenn.12 MAIDEN NAME OF MOTHER Eliz. Walker13 BIRTHPLACE OF MOTHER (State or country) D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington San. & Hosp.(Address) Records, Takoma Park, Md.15 Filed Dec 15, 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 15, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 1921 to December 15, 1930that I last saw her alive on December 15, 1930and that death occurred on the date stated above, at 12:40 a.m.

The CAUSE OF DEATH * was as follows:

Cancer (Pylorus) ?

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Hypertension
Secondary(Duration) 12 yrs. ____ mos. ____ ds.(Signed) Dr. H. E. White + Dr. H. E. Thomas D.
12/15/1930 (Address) Takoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence College Park, Md.19 PLACE OF BURIAL OR REMOVAL Washington, D.C. DATE OF BURIAL 12/15, 193020 UNDERTAKER M. T. Zirkle ADDRESS 301-E Capitol St. Wash. D.C.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated exactly, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

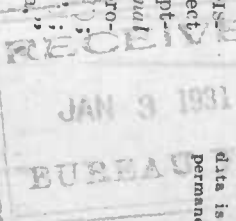
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and exhaustion), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *A accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

15163

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213

Village or City

Rockville

(No.)

Chestnut Lodge Sanitarium

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Susie P. Martin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED
OR DIVORCED
(Write the word)Divorced

6 DATE OF BIRTH

April 30

(Month)

(Day)

1876
(Year)

7 AGE

54

yrs.

7

mos.

27

ds.

or min. ?

If LESS than
1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or
particular kind of workManager(b) General nature of industry
business, or establishment in
which employed or (employer)Restaurant

9 BIRTHPLACE

(State or country)

Tennessee10 NAME OF
FATHERBenjamin H. Plain11 BIRTHPLACE
OF FATHER

(State or country)

Va12 MAIDEN NAME
OF MOTHERSue Tennyson13 BIRTHPLACE
OF MOTHER

(State or country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. M. E. Heru

(Address)

1609-31st St. N.W. Wash. D.C.

15

Filed

12/27

1923

Mrs. H. T. Pratt

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 27, 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Dec 22, 1930, to Dec 27, 1930that I last saw her alive on Dec 27, 1930and that death occurred on the date stated above, at 7:50 m.

The CAUSE OF DEATH was as follows:

Toxic Nephrosis - cloudy swelling
of Kidneys & Liver, cloudy swelling
of Myocardium (ascertained by autopsy)

(Duration)

yrs.

mos.

ds.

Contributory
SecondaryBarbitel Intoxication

(Duration)

yrs.

mos.

ds.

(Signed)

Dexter M. Bullard

M. D.

(Address)

Rockville Md*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury; and (2) whether
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-
ients, or Recent Residents)

At place

of death

yrs.

mos.

5

In the

State

yrs.

mos.

5Where was disease contracted,
if not at place of death?New JerseyFormer or
usual residenceWashington D.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D.C.Dec 30, 1930

20 UNDERTAKER

ADDRESS

Almus R. Speare1623 Conn Ave
Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Coal engineer*, *Stationery fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered a *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia").

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, STRICKEN, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by curbelic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JAN 6 1911
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Poolesville No. _____

2 FULL NAME Joseph Carr Mason

05712

(48)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 2/2

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Wed
(Write the word)

6 DATE OF BIRTH Sept 2, 1841
(Month) (Day) (Year)

7 AGE 83 yrs. 8 mos. 5 ds. or _____ min. IF LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work at home
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) W. Va.

10 NAME OF FATHER Joseph Carr

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Emeline Smith

13 BIRTHPLACE OF MOTHER (State or country) W Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E H Crook

(Address) Poolesville

15 Filed May 7 1930 E W White
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 7, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 7, 1929 to May 7, 1930, that I last saw him live on May 6, 1930, and that death occurred on the date stated above, at 5 A. m.

The CAUSE OF DEATH * was as follows:

Gangrenoma of left leg - large papilloma of skin on anterior part of leg (Cancer of skin). Ulcers
(Duration) 2 yrs. _____ mos. _____ ds.

Contributory Ulcers
Secondary Ulcers, middle third of left leg, anterior
(Duration) 7 yrs. _____ mos. _____ ds.

(Signed) E W White M. D.
May 7, 1930 (Address) Poolesville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Clarksburg, W. Va. DATE OF BURIAL May 10, 1930

20 UNDERTAKER Hilfson & Hall ADDRESS Poolesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or—At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; shop pneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 8 1930
BUREAU OF
CENSUS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

12558

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213

Village or City Rockville (No. 229 1st Montgomery St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Isabelle Mason

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH August 12th, 1848
(Month) (Day) (Year)

7 AGE 82 yrs. 2 mos. 7 ds. or min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Charles Town, W. Va.

10 NAME OF FATHER J. H. Simpson

11 BIRTHPLACE OF FATHER (State or country) Bath, Me.

12 MAIDEN NAME OF MOTHER Mary C. Stephenson

13 BIRTHPLACE OF MOTHER (State or Country) White Post Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Theodore S. Mason
(Address) Rockville, Maryland

15 Filed 10-20 19230 Mrs W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 19th, 19230
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from August 19230 to October 19, 19230, that I last saw her alive on Oct. 18, 19230,

and that death occurred on the date stated above, at 6:30 P. M.
The CAUSE OF DEATH * was as follows:

Natural regurgitation

(Duration) 10 yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. O. Hartley M. D.
Oct. 20 1930 (Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Charles Town W. Va. DATE OF BURIAL October 21, 1930

20 UNDERTAKER Almus R. Speare Inc. ADDRESS 1623 Conn Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1930
BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Wt.

Village or City Silver Spring (No. 74a)

2 FULL NAME William Eli Mathew

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH May 23 1860
(Month) (Day) (Year)

7 AGE 70 yrs. 0 mos. 14 ds. If LESS than 1 day... hrs. or... min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) va.

10 NAME OF FATHER Thomas Mathew

11 BIRTHPLACE OF FATHER (State or country) vt.

12 MAIDEN NAME OF MOTHER Hubbards

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucian Hawland

(Address) Silver Spring, Md.

15 Filed June 7 1930 J. E. Dudley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 6 1930
(Month) (Day) (Year).....

17 I HEREBY CERTIFY, That I attended the deceased from Feb 4 1930 to June 6 1930.

that I last saw him alive on June 6 1930.

and that death occurred on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH * was as follows:

Encephalitis cerebral

(Duration) 14 yrs. 0 mos. 0 ds.

Contributory Secondary arteriosclerosis

(Duration) 15 yrs. 0 mos. 0 ds.

(Signed) W. R. Warner M. D.

June 6 1930 (Address) Silver Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 2 mos. 2 ds. In the State va. yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? va.

Former or usual residence va.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington D.C. June 7 1930

20 UNDERTAKER ADDRESS

Martin W. Hyson 1300 N. W. W.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever (the only definite synonym is "Epidemic cerebro-spinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid Pneumonia"); Labor pneumonia, Bronchopneumonia ("Pneumonia,"*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. 3.

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Rockville(No. Chestnut Lodge Sanitarium St. Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Robert N. Mayo

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Widowed

6 DATE OF BIRTH

Sept 13 1857

(Month) (Day) (Year)

7 AGE

73 yrs. 2 mos. 2 ds. or min. ?

If LESS than

1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Ministry

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Virginia

10 NAME OF FATHER

John H F Mayo

11 BIRTHPLACE OF FATHER

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Ellen Pope

13 BIRTHPLACE OF MOTHER

(State or country)

Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Edward H. Murray

(Address)

Windsor Ave, Md.

15

Filed 11/16 1930 Wm H. T. Place

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 15 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Mar 16 1929 to Nov 15 1930that I last saw him alive on Nov 15 1930and that death occurred on the date stated above, at 9:15 P.m.

The CAUSE OF DEATH was as follows:

Chronic Myocarditis

(Duration) yrs. mos. ds.

Contributory
SecondaryParkinson's Disease

..... (Duration) yrs. mos. ds.

(Signed)

Dr. M. Bullard M.D.Nov. 15 1930 (Address) Rockville Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 1 yrs. 7 mos. 29 da. In the State, 1 yrs. 7 mos. 29 da.Where was disease contracted, unknown
if not at place of death?Former or usual residence Washington, D.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

West River Arundel Co. Nov 17 1930

20 UNDERTAKER

ADDRESS

W.R. Pumphrey Jr Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

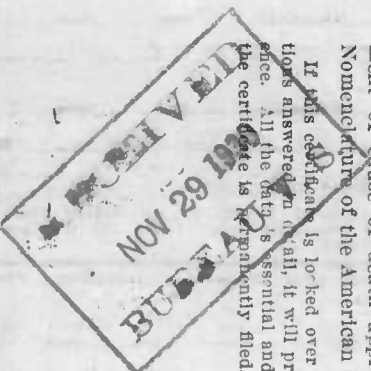
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Splinter*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maunager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *days*; *Bronchopneumonia* (secondary), 10 *days*. Never report mere symptoms or terminal conditions, such as "asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, STRIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in full, it will prevent further correspondence. All the data's essential and must be obtained before the certificate is permanently filed.



WRITE PENCIL WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Dickerson (No.

2 FULL NAME

Rebekah Mc Clow

STATE OF MARYLAND
CERTIFICATE OF DEATH

04467

(75-6)

Registration Dist. No. 212

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Oct. 30, 1921

(Month)

(Day)

(Year)

7 AGE

8 yrs. 5 mos. 17 ds.

If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

O. F. Mc Clow

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Alice M. Clow

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

O. F. Mc Clow, Dickerson, Md.

(Address)

15

Filed

Apr. 17 1930 Mrs. C. C. Hilton Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 17, 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Apr. 13 1930 to Apr. 16 1930

that I last saw him alive on Apr. 16 1930

and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH * was as follows:

Cerebral Diplegia

From Birth

(Duration) 8 yrs. 5 mos. 17 ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) Samuel E. Hoke M. D.

Apr. 17 1930 (Address) ADAMSTOWN, MD.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Olivet Cem. Fred

April 19, 1930

20 UNDERTAKER

ADDRESS

M. R. Etchison Son

Fredericks, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as *Asthenia*, "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Tranition*," "*Marasmus*," "*Old Age*," "*Shock*," "*Uræmia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
MAY 6 1930
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		09388		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Alney</u> (No. <u>114</u>)		Registration Dist. No. <u>217</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>John McClelland</u> <u>Montgomery</u> <u>10 Hospital</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>M</u>	4 COLOR OR RACE <u>N</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)			
6 DATE OF BIRTH <u>Oct 11 1867</u> (Month) (Day) (Year)					
7 AGE <u>62 yrs. 10 mos. 8 ds.</u> or LESS than 1 day hrs. min.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farm</u> (b) General nature of industry business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Va.</u>					
PARENTS	10 NAME OF FATHER <u>N. C. McClelland</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Va</u>				
	12 MAIDEN NAME OF MOTHER <u>Jane Beckley</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Va</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Beckwith</u> (Address) <u>Beltsville Md</u>					
15 Filed <u>Aug 23 1930</u> <u>C. S. Sarnesley</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>8/27/1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>8/20/1930</u> to <u>8/27/1930</u> , 1930, that I last saw him alive on <u>8/25/1930</u> , 1930, and that death occurred on the date stated above, at <u>10:30</u> m. The CAUSE OF DEATH * was as follows: <u>Acute Illness - colic</u> (Duration) yrs. mos. ds. <u>10</u>					
Contributory Secondary (Duration) yrs. mos. ds. <u>10</u>					
(Signed) <u>J. M. Beckwith</u> M. D. <u>8/26/1930</u> (Address) <u>Beltsville, Md</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds.					
Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL <u>St. Marks Fairland Rd</u> <u>Aug 28, 1930</u>					
20 UNDERTAKER ADDRESS <u>Wm. H. Kaiser</u> <u>Land real</u>					

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

fee issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc.; If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

SEP 4 1930
BUREAU OF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Cherry Chase (No. 4107 Beland St. St. Ward)

2 FULL NAME Effie Larisa McClure

10549 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH June 10, 1861
(Month) (Day) (Year)

7 AGE 69 yrs. 2 mos. 25 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Missouri

10 NAME OF FATHER George M. Ochiltree

11 BIRTHPLACE OF FATHER (State or country) Ohio

12 MAIDEN NAME OF MOTHER Nancy T. Emerson

13 BIRTHPLACE OF MOTHER (State or Country) Indiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William H. Smith
4107 Beland St.
(Address) Cherry Chase, Md.

15 Filed Sept 5 1930 Bert C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 5, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from Oct 15 1929 to Sept. 5, 1930
that I last saw him alive on Sept 5, 1930

and that death occurred on the date stated above, at 6-28 a.m.
The CAUSE OF DEATH * was as follows:

Acute dilatation of heart

Contributory (Duration) ____ yrs. ____ mos. ____ ds.
Secondary Chronic myocarditis

(Signed) E. G. Bauersfeld M. D.
9/5/30 (Address) Berthel's Rd

*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rockville Union Cem. DATE OF BURIAL Sept 7, 1930

20 UNDERTAKER W R Humphrey Jr ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup."); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU

OCT 2 1920

WRITE MAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Pr. George.Village or City Lanham Md. (No. _____)2 FULL NAME Edward McDonald.

06891

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 245

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED S
(Write the word)

6 DATE OF BIRTH June 15, 1930
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min.?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work 0
(b) General nature of industry, business, or establishment in which employed or (employer) 0

9 BIRTHPLACE (State or country) Pr. Geo. Co. Md.

10 NAME OF FATHER Joseph McDonald

11 BIRTHPLACE OF FATHER (State or country) Wash DC.

12 MAIDEN NAME OF MOTHER Mary Ella Hanley.

13 BIRTHPLACE OF MOTHER (State or country) Wash DC.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother(Address) Lanham Md.

15 Filed June 15 1930 Mrs. Jas. Severe Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 15, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 15, 1930 to June 15, 1930, that I last saw him June 15, 1930, and that death occurred on the date stated above, June 15, 1930 m.

The CAUSE OF DEATH * was as follows:

Still Born

(Duration) yrs. mos. ds.
Contributory Vomiting & Cough of
Secondary Mother
(Signed) J. A. Bennett M. D.
June 15 1930 (Address) Wash DC.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Bladensburg Md DATE OF BURIAL June 16 1930

20 UNDERTAKER G. E. Gascher Sons ADDRESS Bladensburg Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory," (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUL 9 1930
BUREAU

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Rockville (No. _____)

2 FULL NAME Rosa M. M^c Donald.

6576

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Jan. 31, 1847
(Month) (Day) (Year)

7 AGE 82 yrs. 11 mos. 15 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland.

10 NAME OF FATHER J. Zakkanech. Holland

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura S. Williams.

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Worthington Tulbott.

(Address) Rockville, Md.

15 Filed 1/8 1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 10, 1930
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from 10/31 1929 to 1/6 1930
that I last saw her alive on 1/6 1930

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH * was as follows:

Chronic myocarditis

Contributory (Duration) 5 yrs. 5 mos. 5 ds.
Secondary Chronic nephritis

(Signed) C. E. Henry M. D.
1/7 1930 (Address) Rockville, Md.

*State the disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville Union DATE OF BURIAL Jan 8, 1930

20 UNDERTAKER W. R. Humphrey, Jr. ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1930

BUREAU OF

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

08165

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213

Village or City Rockville (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME, instead of street and number.)

2 FULL NAME James H. Mc Dowell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH July 5 1854
(Month) (Day) (Year)

7 AGE 76 yrs. 0 mos. 15 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer) Merchant

9 BIRTHPLACE (State or country) Delaware

10 NAME OF FATHER David C. McDowell

11 BIRTHPLACE OF FATHER (State or country) Pa

12 MAIDEN NAME OF MOTHER Prudence J. Hardey

13 BIRTHPLACE OF MOTHER (State or Country) N. J.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. McDowell
(Address) 2421-15th St. N.W. D.C.

15 Filed 7/20 1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 8, 1929, to July 16, 1930, that I last saw him alive on July 19, 1930, and that death occurred on the date stated above, at 4 a.m.. The CAUSE OF DEATH * was as follows:

Chronic Myocarditis

Contributory Secondary (Duration) yrs. mos. ds. Arterio-sclerosis

(Signed) Ernest L. Prescott M. D.
July 20, 1930 (Address) Rockville, Md.

*State the Cause Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 3 mos. 12 ds. In the State 1 yrs. 2 mos. 12 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Washington, D. C.

19 PLACE OF BURIAL OR REMOVAL North - D.C. DATE OF BURIAL 7-20, 1930

20 UNDERTAKER A. R. Spears ADDRESS North - D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugster, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

10550

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country)10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Contributory
Secondary

(Signed) M. D.

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "foreman," "manager," "dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia Lobar pneumonia, Bronchopneumonia" ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary, 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-ate), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT 7 1920
BUREAU

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bro. chypneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 7 1920
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Linden (No. _____)

2 FULL NAME Bettie Julia Mc Inturff

01820 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH April 13th 1865
(Month) (Day) (Year)

7 AGE 64 yrs. 9 mos. 5 ds. If LESS than 1 day ____ hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Woodstock Va.

PARENTS
10 NAME OF FATHER John H. Dellinger
11 BIRTHPLACE OF FATHER (State or country) Woodstock Va.
12 MAIDEN NAME OF MOTHER Jane Hottel
13 BIRTHPLACE OF MOTHER (State or country) Belknap Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James F Davidson
(Address) 203 Elm C C Rd

15 Filed Feb 19 1923 J E. Dudley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2-18-30, 192____
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 2-7-30 192____ to 2-18-30 192____, that I last saw her alive on 2-18-30 192____, and that death occurred on the date stated above, at 4:15 p. m. The CAUSE OF DEATH * was as follows:
Apoplexy

(Duration) ____ yrs. ____ mos. 12 ds.
Contributory Secondary Acute myocarditis

(Signed) James F Davidson M. D.
192____ (Address) 203 Elm C C Rd

State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Woodstock, Va DATE OF BURIAL 2-20- 1930

20 UNDERTAKER Thos. S. Sargent ADDRESS Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

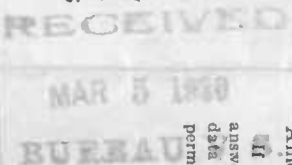
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		6577		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Bethesda</u> (No. <u>512 Park Lane</u>)		St. _____ Ward _____		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Frank G. Mears</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>Nov. 16, 1864</u> (Month) (Day) (Year)					
7 AGE <u>66</u> yrs. <u>0</u> mos. <u>19</u> ds. or min. If LESS than 1 day, hrs.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>					
10 NAME OF FATHER <u>Peter Mears</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>U. S.</u>					
12 MAIDEN NAME OF MOTHER <u>Unknown</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>U. S.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Norace Mears</u> (Address) <u>Bethesda, Md.</u>					
15 Filed <u>1/15/30</u> 19 <u>30</u> <u>Berg C. Perry</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan. 15, 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan. 13, 1930</u> to <u>Jan. 15, 1930</u> that I last saw him alive on <u>Jan. 15, 1930</u> and that death occurred on the date stated above, at <u>1:32</u> a. m. The CAUSE OF DEATH * was as follows: <u>Lobar pneumonia</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>Berg C. Perry</u> M. D. <u>1/15/30</u> (Address) <u>Bethesda, Md.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>W. E. Humphrey</u>				DATE OF BURIAL <u>1/16, 1930</u>	
20 UNDERTAKER <u>Mercersburg, Pa</u>				ADDRESS <u>Rockville, Md.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, lœquies*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

FEB 5 1930

BUREAU

08166

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223

PLACE OF DEATH

County MontgomeryVillage or City Lakona Park (No. Washington Sanatorium Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Mrs Hattie Melvin Needs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)6 DATE OF BIRTH July 5, 1863
(Month) (Day) (Year)7 AGE 66 yrs. 11 mos. 21 ds. IF LESS than 1 day, hrs. or min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer).9 BIRTHPLACE (State or country) Washington D.C.10 NAME OF FATHER Mr B. F. Van Horn11 BIRTHPLACE OF FATHER (State or country) Washington D.C.12 MAIDEN NAME OF MOTHER Sarah A. Nulin13 BIRTHPLACE OF MOTHER (State or country) Washington D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanatorium Records(Address) Lakona Park Md.15 Filed July 1, 1930 Registrar H. E. Lewis

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 1, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from June 28, 1930 to July 1, 1930, that I last saw her alive on July 1, 1930, and that death occurred on the date stated above, at 4:05 P.M.
The CAUSE OF DEATH * was as follows:Lobar Pneumonia
(Duration) yrs. mos. ds. 10 ds.Contributory Secondary
(Duration) yrs. mos. ds. 10 ds.(Signed) J. G. Thompson M. D.
July 1, 1930 (Address) Lakona Park Md.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. 3 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 11 Pine Ave Lakona Park Md.19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL July 3, 193020 UNDERTAKER W. W. Chambers ADDRESS 1400 Chesapeake St.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND
CERTIFICATE OF DEATH

DATE OF DEATH

RECEIVED

AUG 5 1930

BUREAU V.S.

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Montgomery

Village or City

Takoma Park (No. 201 Willow Ave.)

2 FULL NAME

Sarah Virginia Melton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Widowed

6 DATE OF BIRTH

May 7, 1852

7 AGE

78 yrs. 3 mos. 28 ds. or min.?

If LESS than
1 day hrs.
1 day min.?

8 OCCUPATION

(a) Trade, profession or
particular kind of work

None

(b) General nature of industry
business, or establishment in
which employed or (employer)9 BIRTHPLACE
(State or country)

Louisville, Kentucky

10 NAME OF
FATHER

Solomon L. Baker

11 BIRTHPLACE
OF FATHER
(State or country)

Kentucky

12 MAIDEN NAME
OF MOTHER

Nancy Southers

13 BIRTHPLACE
OF MOTHER
(State or Country)

Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Vera L. Melton

(Address)

201 Willow Ave. Takoma Park, Md.

15

Filed Sept 2, 1930

H. E. Rogers
RegistrarSTATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

St. Ward

(If death occurred in
a hospital or institution,
give its NAME instead of
street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 1, 1930

17 I HEREBY CERTIFY, That I attended the deceased from

Sept. 1, 1930 to Sept 1, 1930

that I last saw her alive on Sept. 1, 1930,

and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH * was as follows:

Thrombosis of central vessel

(Duration) yrs. mos. 1 da.

Contributory
Secondary

Myocarditis

(Duration) 2 yrs. 1 mos. 0 da.

(Signed)

W. R. Hayman M.D.

Sept. 2, 1930 (Address) 952 1/2 Ave. Libby

*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. da.

In the State yrs. mos. da.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

Washington, D.C.

DATE OF BURIAL

Sept. 3, 1930

20 UNDERTAKER

Almus R. Speare

ADDRESS

1623 Conn. Ave.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., requesting V. S. No. 1.

Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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OCT 6 1930

BUREAU OF

N.B. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Sellman (No. _____)

2 FULL NAME Richard C. Mercer

13922

(129)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 212

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH about 1845 1 _____ (Month) (Day) (Year)

7 AGE about 85 yrs. _____ mos. _____ ds. or _____ min. 2 If LESS than 1 day _____ hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Laborer (b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Caswell Mercer

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Mercer
(Address) Sellman, Md.

15 Filed Nov 28, 1930 E. W. White Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 26, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 1928 to Nov, 1930 that I last saw him live on Oct 31, 1930

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH * was as follows:

Chronic Interstitial Nephritis and Congestive Heart Disease

(Duration) 3 yrs. _____ mos. _____ ds.

Contributory Secondary Acute Myocarditis

(Duration) _____ yrs. _____ mos. 10 ds.

(Signed) E. W. White M. D. Nov 29, 1930 (Address) E. W. White

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Mt. Zion DATE OF BURIAL 11/30, 1930

20 UNDERTAKER W. D. Hillen House Barnesville ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a)

Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 4 1933

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Takoma Park, Md. Washington San. Hosp.

2 FULL NAME Mrs. Lizzie C. Merry

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH October 2, 1857
(Month) (Day) (Year)

7 AGE 72 yrs. 10 mos. 4 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Armenia, N.Y.

10 NAME OF FATHER George Wash. Center

11 BIRTHPLACE OF FATHER (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Eliz. Rundall

13 BIRTHPLACE OF MOTHER (State or country) N.Y.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wash. San. Hosp. Records
(Address) Takoma Park, Md.

15 Filed Aug 5, 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 5, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 5, 1930 to August 5, 1930
that I last saw her alive on August 5, 1930,
and that death occurred on the date stated above, at 2:10 a.m.

The CAUSE OF DEATH * was as follows:

Chronic myocarditis

(Duration) 2 yrs. 10 mos. 4 ds.
Contributory Senility
Secondary

(Signed) Donald C. Nelson M. D.
Aug 5, 1930 (Address) Takoma Pk. Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death, 1 yrs. 1 mos. — ds. In the State, — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence McLean, Va.

19 PLACE OF BURIAL OR REMOVAL Clarendon, Va. DATE OF BURIAL Aug 8, 1930

20 UNDERTAKER C. J. Dues ADDRESS 78 N. Spruce Clarendon, Va.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE AIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Silver Spring, Md.2 FULL NAME Agalia Bowen Miller03106 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH
March 26, 1857
(Month) (Day) (Year)7 AGE
73 yrs. 0 mos. 11 ds. or min.?
If LESS than 1 day ____ hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed or (employer) _____9 BIRTHPLACE
(State or country) Maryland10 NAME OF FATHER
Charles Williams11 BIRTHPLACE OF FATHER
(State or country) England12 MAIDEN NAME OF MOTHER
Virginia E. Husey13 BIRTHPLACE OF MOTHER
(State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. George C. House(Address) 1114 Oak St., Silver Spring, Md.15 Filed May 9 1930 J. E. Whisler Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
March 7, 1930.
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from
Jan. 8 1930 to Mar. 7, 1930,
that I last saw her alive on Mar. 7, 1930,and that death occurred on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH * was as follows:

General Arterio-sclerosis.Contributory Secondary
(Duration) 2 yrs. ____ mos. ____ ds.
Cardiac Failure.(Signed) F. A. Connor M. D.
Mar. 7, 1930. (Address) 2026-16th St., Washington, D. C.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL
Cedar Hill Cemetery DATE OF BURIAL
Mar. 10, 193020 UNDERTAKER
Warner E. Humphrey ADDRESS
Rockville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material world on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by rolling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 7 1930
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Bethesda (No. Wilson Lane St. Ward)

2 FULL NAME Charles H. Miller

01821 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Sept 9 1840
(Month) (Day) (Year)

7 AGE 89 yrs. 5 mos. 1 ds. or min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Michigan

10 NAME OF FATHER Charles Miller

11 BIRTHPLACE OF FATHER (State or country) Michigan

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Michigan

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A. Darcey
(Address) Bethesda Md

15 Filed Feb. 11 1930 Bern C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 10 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 4th 1930 to Feb. 10th 1930, that I last saw him alive on Feb. 10th 1930,

and that death occurred on the date stated above, at 1:58 m.
The CAUSE OF DEATH was as follows:

Brachipneumonia

(Duration) ____ yrs. ____ mos. ten ds.

Contributory Secondary

(Signed) Wheeler M. D.
Feb. 11th 1930 (Address) Bethesda, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wilmington National Cemetery DATE OF BURIAL Feb 12 1930

20 UNDERTAKER Gen. St. Elise Co. ADDRESS Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E-haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 4 1930

BUREAU

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1 PLACE OF DEATH
County Montg.

Village or City Sligo Spring (No. _____)

2 FULL NAME Dorothy E. Miller

03107

(100-0)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH June 23, 1929
(Month) (Day) (Year)

7 AGE 9 yrs. 14 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER F. Mason Miller

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margruth Barnes

13 BIRTHPLACE OF MOTHER (State or Country) Washington D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. Mason Miller

(Address) Sligo and Sligo Springs

15 Filed Mar 7, 1930 J. E. Blundell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 7, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 1, 1930 to March 7, 1930
that I last saw her alive on March 6, 1930
and that death occurred on the date stated above, at 3 A. m.
The CAUSE OF DEATH * was as follows:

Broncho Pneumonia

(Duration) ____ yrs. ____ mos. 2 ds.

Contributory Acute Intestinal Nephritis
Secondary (Duration) ____ yrs. ____ mos. 2 ds.

(Signed) W. H. Hays M. D.
March 7, 1930 (Address) Sligo Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL 3/8/1930

20 UNDERTAKER Harmon E. Humphrey ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Form laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Edema," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 7 1930
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Linwood, Silver Spring, Md., R.R. No. 1

Registration Dist. No.

214

Ward

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

MILLER-VINCENT

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

March 14, 1930
(Month) (Day) (Year)

7 AGE

If LESS than 1 day....hrs.

.....yrs.....mos.....ds. or 0 min. ?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Linwood, Silver Spring, Md.

10 NAME OF FATHER

Miller, Eugene Sebastian

11 BIRTHPLACE OF FATHER

(State or country)

Caroline Co. Va.

12 MAIDEN NAME OF MOTHER

Clark Anna Della

13 BIRTHPLACE OF MOTHER

(State or country)

Alabama

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eugene Sebastian Miller

(Address)

Silver Spring, Md.

15

Filed *Mar 15* 1930*J. E. Dudley*

Registrar

Deputy

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 14, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

3-14-1930 to *3-14-1930*that I last saw him alive on *3-14-1930*and that death occurred on the date stated above, at *8:45 P.M.*

The CAUSE OF DEATH was as follows:

*Stillbirth*Contributory
Secondary

(Duration)yrs.....mos.....da.

(Signed)

E. S. Mitchell

M. D.

3-14-1930 (Address) *Silver Spring, Md.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....da.

In the State,.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lincoln Md

, 19.....

20 UNDERTAKER

ADDRESS

E. S. Miller (Father)

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automotive factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease, state **CAUSE OF DEATH**, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiorenal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Typhoid"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.; *Carcinoma*, *Sarcoma*, etc., of (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Erbiasia," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbofic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is locked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930
BUREAU

WRITE MAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Barnesville (No.)

2 FULL NAME Unnamed Still Born Premature Infant

0578

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 21 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH 10 10 1930
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or 0 min. IF LESS than 1 day, 2 hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Barnesville Md

10 NAME OF FATHER Rodger F. Miller

11 BIRTHPLACE OF FATHER (State or country) va.

12 MAIDEN NAME OF MOTHER Margaret E. Jacobs

13 BIRTHPLACE OF MOTHER (State or country) va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret E. Miller
(Address) Barnesville Md

15 Filed Jan 11 1930 Mrs. C. C. Hilton Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 10 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from at Birth 10.10.1930 to , 1930, that I last saw her at Barnesville 10.10.1930, and that death occurred on the date stated above, at 12 noon

The CAUSE OF DEATH * was as follows:

Premature birth (Hydrocephalus)

Contributory
Secondary

(Signed) Z. J. Miller M. D.
10.10.1930 (Address) Barnesville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL Barnesville Md DATE OF BURIAL 10-11-1930

20 UNDERTAKER W. T. Miller ADDRESS Barnesville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocer; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Peeler," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Bacterial pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc.*; of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *23 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

FEB. 4 1920

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County *Montg.*

Village or City *Saithurstburg*

2 FULL NAME *James A. Mills*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *whit.* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *married*

6 DATE OF BIRTH *Aug 12*, 18*53*
(Month) (Day) (Year)

7 AGE *76* yrs. *11* mos. *1* ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work *Farmer*
(b) General nature of industry business, or establishment in which employed or (employer) *"*

9 BIRTHPLACE (State or country) *Md.*

10 NAME OF FATHER *Richard H. Mills*

11 BIRTHPLACE OF FATHER (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Mary S. Safell*

13 BIRTHPLACE OF MOTHER (State or country) *Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Mary Mills*

(Address) *Saithurstburg*

15 Filed *July 15* 19*30* *Paul R. DeBelle*
Registrar

08168

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. *218*

St. ____ Ward ____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 13*, 19*30*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from *Jan 3* 19*30* to *July 13*, 19*30*.
that I last saw him alive on *July 11*, 19*30*.

and that death occurred on the date stated above, at *11 P* m.
The CAUSE OF DEATH was as follows:

Chronic myocarditis

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory *acute colitis*
Secondary

(Signed) *Stanley W. Barber* M. D.
15 July 1930 Address *Saithurstburg Md*

*State the Cause Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Saithurstburg Md *July 16*, 19*30*

20 UNDERTAKER *E. C. Sartor* Address *Saithurstburg Md.*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 6 1930

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Quince Orchard

2 FULL NAME John W. Mills

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH June 11, 1862
(Month) (Day) (Year)

7 AGE 68 yrs. 5 mos. 28 ds. or min.?
If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed or (employer) Same

9 BIRTHPLACE (State or country) MD.

10 NAME OF FATHER Richard Mills

11 BIRTHPLACE OF FATHER (State or country) MD.

12 MAIDEN NAME OF MOTHER Mary Sparrow

13 BIRTHPLACE OF MOTHER (State or Country) MD.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. W. Mills

(Address) Guthrie, Md.

15 Filed 12/10 1930 Mrs. W. T. Pratt
Registrar

15164

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2/3

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 9, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec. 8, 1930 to Dec. 9, 1930
that I last saw him alive on Dec. 8, 1930

and that death occurred on the date stated above, at 4:15 am.
The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage
(Duration) _____ yrs. _____ mos. 2 ds.

Contributory
Secondary

(Signed) Stanley W. Barber M. D.
8 Dec 1930 Address Guthrie, Md.

*State the disease causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 68 yrs. 5 mos. 28 ds. In the State Same yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL Larnstown, Md. DATE OF BURIAL Dec. 11, 1930

20 UNDERTAKER E. C. Palmer ADDRESS Guthrie, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by running train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 6 1931

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1 PLACE OF DEATH
County Montg.

Village or City Mr. Darlington (No.)

2 FULL NAME

Howard Mills

08167

(113)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE wht 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 19, 1930
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 17 ds. or 17 min. If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER H. P. Mills

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Maude Love

13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

H. P. Mills
Germantown

15 Filed July 7, 1930 Upd. I. W. W. R. S.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 6 - 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 19, 1930 to July 6, 1930
that I last saw him alive on July 6, 1930
and that death occurred on the date stated above, at 1:45 P. m.
The CAUSE OF DEATH * was as follows:

Impetigo

Contributory
Secondary

(Duration) _____ yrs. _____ mos. 5 ds.

(Signed) Stanley W. Barber M. D.
July 7, 1930 (Address) Germantown, Md.

*State the Disease Causing Death, or, in death from violent causes, state (1) Means of Injury and (2) Whether accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. 17 ds. In the State _____ yrs. _____ mos. 17 ds.

Where was disease contracted, if not at place of death? none

Former or usual residence none

19 PLACE OF BURIAL OR REMOVAL

Guthrie DATE OF BURIAL July 8, 1930

20 UNDERTAKER H. P. Humphrey Jr. ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u> Village or City <u>near Quince Orchard</u>			08169 STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>213</u> St. <u>1st</u> Ward <u>Swine</u> (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>Mills</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>M.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>7/27/30</u> (Month) (Day) (Year)					
7 AGE <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. or <u>6</u> hrs. or <u>1</u> min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed or (employer)					
9 BIRTHPLACE (State or country) <u>MD.</u>					
10 NAME OF FATHER <u>Lawrence Mills</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>MD.</u>					
12 MAIDEN NAME OF MOTHER <u>Irene Briggs</u>					
13 BIRTHPLACE OF MOTHER (State or Country) <u>MD.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lawrence Mills</u> (Address) <u>Farmersburg, Md.</u>					
15 Filed <u>7/28</u> 19 <u>30</u> <u>Upm</u> <u>1</u> <u>found</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>7/27/30</u> 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>7/27/30</u> 19 <u>30</u> to <u>7/27/30</u> 19 <u>30</u> , that I last saw him alive on <u>7/27/30</u> 19 <u>30</u> , and that death occurred on the date stated above, at <u>7:30 P.M.</u> The CAUSE OF DEATH was as follows: <u>Premature Birth</u>					
(Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.					
Contributory Secondary (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. (Signed) <u>Stanley W. Bashner</u> M. D. <u>7/28/30</u> (Address) <u>Farmersburg, Md.</u> State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) <u>Same</u> At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? <u>Same</u> Former or usual residence <u>Same</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Farmersburg, Md.</u> DATE OF BURIAL <u>7/28/30</u>					
20 UNDERTAKER <u>E. C. Garner</u> ADDRESS <u>Farmersburg, Md.</u>					

(Approved by U. S. Census and American Public Health Association.)

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

BUREAU V. S.

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		08170		STATE OF MARYLAND CERTIFICATE OF DEATH	
near <u>Guinne Orchard</u>		(16-2)		Registration Dist. No. <u>213</u>	
Village or City <u>Guinne Orchard</u>		St. <u>2nd</u> Ward <u>Swain</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <u>Mills</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>F.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	16 DATE OF DEATH <u>7/27/30</u> , 192 <u>2</u>		
6 DATE OF BIRTH <u>7/27/30</u> , 192 <u>2</u>			(Month) (Day) (Year)		
7 AGE <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. or <u>0</u> min.?			17 I HEREBY CERTIFY, That I attended the deceased from <u>7/27/30</u> to <u>7/27/30</u> 192 <u>2</u> , that I last saw him alive on <u>7/27/30</u> 192 <u>2</u> , and that death occurred on the date stated above, at <u>2:35 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Premature Birth (5 1/2 mos)</u>		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry business, or establishment in which employed or (employer)			Contributory Secondary (Duration) yrs. mos. ds.		
9 BIRTHPLACE (State or country) <u>MD</u>			(Signed) <u>Stanley W. Barber</u> M. D. <u>7/28/30</u> (Address) <u>Yakobsky, Md</u>		
PARENTS	10 NAME OF FATHER <u>Lawrence Mills</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
	11 BIRTHPLACE OF FATHER (State or country) <u>MD</u>	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) <u>5 min</u> <u>Same</u>			
	12 MAIDEN NAME OF MOTHER <u>Irma Briggs</u>	At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>Same</u> yrs. mos. ds.			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>MD</u>	Where was disease contracted, if not at place of death? <u>Same</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lawrence Mills</u> (Address) <u>Yakobsky, Md</u>					
15 Filed <u>7/28</u> 19 <u>30</u> <u>W. S. S. S. S.</u> Registrar					
19 PLACE OF BURIAL OR REMOVAL <u>Yakobsky Md</u>			DATE OF BURIAL <u>7/28/30</u>		
20 UNDERTAKER <u>E. C. Yakobsky</u>			ADDRESS <u>Yakobsky Md</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The maternal worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Chancriforma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 6 1930

BUREAU

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1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St.: Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day... hrs.
or... min.?

8 OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed 12-22 1930

1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows

Contributory
Secondary

(Signed)

12-22 1930

(Address)

*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-
ients or Recent Residents)At place
of deathIn the
StateWhere was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leuæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931
BUREAU V. S.

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1 PLACE OF DEATH

County

Village or City

2 FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

May 15, 1908
(Month) (Day) (Year)

7 AGE

32 yrs. 11 mos. 14 ds. or min.?

IF LESS than
1 day hrs.
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

Machinist

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

4-29 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 29, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from not at all, 192

that I last saw him alive on April 29, 1930.

and that death occurred on the date stated above, at 12:50 P.M.

The CAUSE OF DEATH * was as follows:

Fracture of skull -
Struck by railway train
accident.

(Duration) Instantaneous

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Wm A. Fentress, M. D.

April 29, 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D.C. 4-29-30

20 UNDERTAKER

ADDRESS

Harold Humphrey Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 8 1930

BUREAU V S

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Cherry Chase (No. 6512 Summit)2 FULL NAME Charles Henry Montgomery15166 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 2-16St. An. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH June 10, 1879
(Month) (Day) (Year)

7 AGE 51 yrs. 6 mos. 14 ds. or min.?
If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Plate Printer
(b) General nature of industry, business, or establishment in which employed or (employer) (Retired)

9 BIRTHPLACE (State or country) Philadelphia, Pa.10 NAME OF FATHER Isaac Montgomery11 BIRTHPLACE OF FATHER (State or country) Ireland12 MAIDEN NAME OF MOTHER Emma Duswald13 BIRTHPLACE OF MOTHER (State or country) Phila. Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clara M. Montgomery
(Address) 6512 Summit Ave.

15 Filed 12-26 1930 Thomas K. Conrad
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 24, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 21, 1920 to Dec. 24, 1930,
that I last saw him alive on Dec. 23, 1930,
and that death occurred on the date stated above, at 2:15 A. m.
The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis(Duration) 12 yrs. 6 mos. ds.Contributory
Secondary Exhaustion(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) Joseph Plinthof Plathof M. D.
Dec. 24, 1930 (Address) 1825 Eys St. W. Wash. D.C.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 12 yrs. 6 mos. 14 ds. In the State 12 yrs. 6 mos. 14 ds.

Where was disease contracted, if not at place of death? at Place of deathFormer or usual residence above19 PLACE OF BURIAL OR REMOVAL Congressional, Wash. D.C. DATE OF BURIAL Dec 26, 193020 UNDERTAKER H. B. Murrie ADDRESS Wash. D. C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *shop pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misadventure as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931

BUREAU

MARGIN RESERVED FOR BINDING
WRITE NAME, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont.

Village or City Brooksville (No.)

2 FULL NAME Samuel Quinton Moody

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED mar
(Write the word)

6 DATE OF BIRTH Oct 12th, 1887
(Month) (Day) (Year)

7 AGE 75 yrs. 10 mos. 29 ds. or LESS than 1 day hrs. min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Shoemaker
(b) General nature of industry business, or establishment in which employed (or employer) Retired

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER John Moody

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Saml. Moody

(Address) Brooksville Md.

15 Filed Sept 12 1930 C S Barnaley
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

10552

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 11th, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 11th 1930 to Sept 11th 1930
that I last saw him dead on Sept 11th 1930

and that death occurred on the date stated above, at 4:57 m.
The CAUSE OF DEATH * was as follows:

Gunsnot wound of skull
(Duration) --- yrs. --- mos. --- ds.

Contributory Suicidal
Secondary (Duration) --- yrs. --- mos. --- ds.

(Signed) Chas C Smithson M. D.
Sept 12 1930 (Address) Sandy Spring

*State the Disease Causing Death, in Deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death --- yrs. --- mos. --- ds. In the State --- yrs. --- mos. --- ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Carmel DATE OF BURIAL Sept 13 1930

20 UNDERTAKER Roy W Barber Fairbury ADDRESS Md

fur issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Arcited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer retired 6 yrs.* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 4 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Rockville (No. Chestnut Lodge Sanitarium Ward 5)15167 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME George F Moore

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Widower</u>
----------------------	---------------------------------	--

6 DATE OF BIRTH

Aug 9 1988
(Month) (Day) (Year)

7 AGE

82 yrs. 3 mos. 25 ds. or min. ?
If LESS than 1 day.... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work Judge
(b) General nature of industry, business, or establishment in which employed or (employer).....

9 BIRTHPLACE
(State or country)Alabama

PARENTS

10 NAME OF FATHER

William H Moore11 BIRTHPLACE OF FATHER
(State or country)Alabama

12 MAIDEN NAME OF MOTHER

Mary M Dixon13 BIRTHPLACE OF MOTHER
(State or country)Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. T. Moore(Address) Aella Vista, Md.

15

Filed 12-4 1992 Mrs. H. T. Pratt

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 4, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

June 22 1928, to Dec 4, 1928,
that I last saw him alive on Dec 4, 1928,
and that death occurred on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH was as follows:

Chronic MyocarditisUnknown (Duration) yrs. mos. da.Contributory Cystitis
Secondary(Signed) Dustin M. Bullard M.D.
Dec 4 1930 (Address) Rockville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 2 yrs. 5 mos. 12 da. In the State, 11 yrs. mos. da.Where was disease contracted, Unknown
if not at place of death?Former or usual residence Bethesda, Md

19 PLACE OF BURIAL OR REMOVAL

Montg, Alabama Dec 7, 1930

20 UNDERTAKER

Wm Parker Humphrey Rockville Md

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered a *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 40 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rever's wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (R commendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. If the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 6 1931

BUREAU V.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Takoma Park (No. Md. Wash. San. + Hosp.)2 FULL NAME Mr. Robert Addison Moore

13923

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223

Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, ☒ MARRIED, ☐ WIDOWED, ☐ OR DIVORCED (Write the word)

6 DATE OF BIRTH January 21, 1909
(Month) (Day) (Year)

7 AGE 21 yrs. 10 mos. 0 ds. or min. IF LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Wilmington, Delaware

10 NAME OF FATHER Alfred B. Moore

11 BIRTHPLACE OF FATHER (State or country) Washington, D.C.

12 MAIDEN NAME OF MOTHER Bessie A. Mills

13 BIRTHPLACE OF MOTHER (State or country) Wilmington, Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records
(Address) Takoma Park, Md.

15 Filed Nov 21 1920 H. E. Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH November 21, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mr. 21st 1930 to Mr. 21st 1930, that I last saw him alive on November 21st, 1930, and that death occurred on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH * was as follows:

Streptococcus meningitidis(Duration) 10 yrs. 10 mos. 0 ds.Contributory
Secondary(Duration) 10 yrs. 10 mos. 0 ds.

(Signed) W. E. Sampson M. D.
11/21 1930 (Address) Takoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 10 mos. 1 ds. In the State 1 yrs. 10 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1337 30th St. D.C.

19 PLACE OF BURIAL OR REMOVAL

Washington D.C.

DATE OF BURIAL

Nov 22, 1930

20 UNDERTAKER

W. W. Chambers

ADDRESS

1400 Chapin St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Paymer retired 6 yrs*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misadventure as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A the date is essential and must be obtained before the certificate is permanently filed.

DEC 5 1933
BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u> Village or City <u>Edgemoor</u> (No. <u>6921</u> , <u>Exeter</u>)			6579 (74a)		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>216</u>	
2 FULL NAME <u>Mary Eliot Moran</u>						[If death occurred in a hospital or institution, give its NAME instead of street and number.]
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>F.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>W.</u>	16 DATE OF DEATH <u>Jan. 6, 1930</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>July 7, 1855</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>Nov. 10, 1929</u> to <u>Jan. 6, 1930</u> that I last saw her alive on <u>Jan. 6, 1930</u>			
7 AGE <u>74</u> yrs. <u>5</u> mos. <u>29</u> ds. OR LESS than 1 day, ____ hrs. ____ min. ?			and that death occurred on the date stated above, at <u>5 p. m.</u> The CAUSE OF DEATH* was as follows: <u>Central Hemorrhage</u> (Duration) ____ yrs. ____ mos. ____ ds.			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>at home</u> (b) General nature of industry, business, or establishment in which employed (or employer)			Contributory <u>Chr. arteriosclerosis</u> Secondary			
9 BIRTHPLACE (State or country) <u>Wash. D.C.</u>			(Signed) <u>E. G. Bauerfeld</u> , M. D. <u>Jan. 7, 1930</u> (Address) <u>Bethesda Md.</u>			
PARENTS	10 NAME OF FATHER <u>Wallace L. Eliot</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
	11 BIRTHPLACE OF FATHER (State or country) <u>not known</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.			
	12 MAIDEN NAME OF MOTHER <u>not known</u>		Where was disease contracted, If not at place of death? Former or usual residence			
	13 BIRTHPLACE OF MOTHER (State or country) <u>not known</u>		19 PLACE OF BURIAL OR REMOVAL <u>Washington, D.C.</u> DATE OF BURIAL <u>Jan. 8, 1930</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. Eliot Moran</u> (Address) <u>6921 Exeter St. Edgemoor Md.</u>						
15 Filed <u>Jan 7, 1930</u> <u>Benj. C. Perry</u> REGISTRAR			20 UNDERTAKER <u>Jos. Lawler's Sons Inc.</u> ADDRESS <u>1754 Parkway</u>			

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

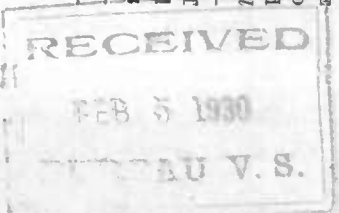
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH
County Montgomery

03109

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213Village or City Rockville, (North) 3

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Anna A. Moulden

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH

Feb. 14, 1867
(Month) (Day) (Year)

7 AGE

63 yrs. 1 mo. 16 ds.
If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country)Maryland

10 NAME OF FATHER

West Thompson11 BIRTHPLACE OF FATHER
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

May C. Beavers13 BIRTHPLACE OF MOTHER
(State or Country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. James Moulden

(Address)

Rockville Md.

15

Filed 4-1 1930 Ms. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 30, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 11, 1930 to March 30, 1930

that I last saw her alive on March 28, 1930

and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH * was as follows:

Senile arteriosclerosis
Chronic myocarditis

(Duration) 2 yrs. ____ mos. ____ ds.Contributory
SecondaryNone

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Wm. C. Lathrop M. D.

Mar. 30, 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.

In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Rockville Union

DATE OF BURIAL

4/2, 1930

20 UNDERTAKER

W. P. Murphy Rockville

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

APR 7 1930

BUREAU

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Wt

03110

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214Village or City Silver Spring (No. 74-2)Middlewood St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William L Mount

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Widowed

6 DATE OF BIRTH

June 7, 1854
(Month) (Day) (Year)

7 AGE

75
769 yrs.? mos.If LESS than
1 day ____ hrs.
1 day ____ mos. ____ ds. or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Va.

10 NAME OF FATHER

F Mount

11 BIRTHPLACE OF FATHER

(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Emily Cooper

13 BIRTHPLACE OF MOTHER

(State or Country)

Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Lucian Harland

(Address)

Silver Spring, Md.

15

Filed Mar 9 1930J. E. Wadsworth

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 9, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Dec 15, 1929, to March 9, 1930that I last saw him alive on March 8, 1930and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH * was as follows:

Ruptured cerebral aneurysm(Duration) ____ yrs. ____ mos. 4 ds.Contributory
SecondaryArteriosclerosis(Duration) 4 yrs. 0 mos. 0 ds.(Signed) Winston A. Hays M. D.March 9, 1930 (Address) Silver Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. 2 mos. 17 ds.

In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Va.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clarendon, Va.Mar 9, 1930

20 UNDERTAKER

ADDRESS

C. J. IvesClarendon, Va.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE AGAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
 County Montgomery
 Village or City Yellow Echo Park (No. 178)
 2 FULL NAME Arlene Moxley
 Registration Dist. No. 216
 St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>7</u> <u>7</u> <u>1925</u> (Month) (Day) (Year)		
7 AGE <u>5</u> yrs. <u>7</u> mos. <u>7</u> ds. If LESS than 1 day <u> </u> hrs. or <u> </u> min.)		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry business, or establishment in which employed or (employer) <u> </u>		
9 BIRTHPLACE (State or country) <u>Md</u>		
10 NAME OF FATHER <u>William Moxley</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>		
12 MAIDEN NAME OF MOTHER <u>Catharine Moxley</u>		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Joe Moxley - (Uncle)
 (Address) Rockville Md.
 15 Filed June 1st 1925 Benj. C. Perry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 1, 1925
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 2 1925 to 1925,
 that I last saw him alive on 1925,
 and that death occurred on the date stated above, at 1 A.M.
 The CAUSE OF DEATH * was as follows:
Burns (Accident)
Home burned during night, while asleep. Cause
unknown. Fifth degree burns. Over 50
 Contributory Supposedly due to electric iron left
 Secondary connected.
 (Duration) yrs. mos. ds.
 (Signed) M. J. Hall M. D.
June 1 1925 (Address) Rockville Md.
 *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted, if not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mount Airy - Md DATE OF BURIAL June 4, 1925
 20 UNDERTAKER W. R. Humphrey Jr ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged as *Housewife, Housework*, or *At Home*, and children as *Housewife, Housework*, or *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 5 1930
BURMAN

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

June 1st 1923

Benj. C. Perry

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Home burned during night, while asleep.

Cause, unknown.

Burns (Accident)

Fifth degree burns. C. & G. R.

Contributory

Suppressed due to electric shock

Secondary

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed) M. J. Pross M. D.

June 1 1923 (Address) Rockville Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

16 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Moulg. Chapel Md. June 4, 1923

20 UNDERTAKER

ADDRESS

W. R. Humphrey Jr Rockville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Glen Echo Park Md.

(No.)

2 FULL NAME

Bessie Moxley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

7 7 1917
(Month) (Day) (Year)

7 AGE

13 yrs. 4 mos. 4 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

School girl

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

William Moxley

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Catharine Moxley

13 BIRTHPLACE OF MOTHER

(State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. C. Moxley (Uncle)
Rockville, Md.

(Address)

15

Filed

June 1st 1923

Benj. C. Berry
Registrar

Registrar

06844

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

St.: Ward:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 1, 1923
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1923 to 1923,

that I last saw him alive on 1923,

and that death occurred on the date stated above, at 17 m.

The CAUSE OF DEATH was as follows:

Burns (Accident)
Home burned during night, while asleep. Cause unknown. Fifth degree burns.

Contributory Secondary

Supposedly due to electric wire left connected.

(Signed) R. J. F. M. D.

June 1, 1923 (Address) Rockville Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Montg Chapel Md

DATE OF BURIAL

June 4, 1923

20 UNDERTAKER

W R Humphrey Jr

ADDRESS

Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUL 5 1930
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS.

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDDED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

06845

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory
Secondary

(Signed)

June 1 1930 (Address) Rockville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Montg Chapel. Md.

June 4. 1930

20 UNDERTAKER

ADDRESS

W R Humphrey &

Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucositis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 5 1935
BUREAU U. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>			06846 STATE OF MARYLAND 178 CERTIFICATE OF DEATH		
Village or City <u>Elm Echo Park - Md.</u> (No. _____)			Registration Dist. No. <u>216</u>		
2 FULL NAME <u>George Moxley</u>			(If death occurred in a hospital or institution, give its NAME instead of street and number.)		
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>?</u> <u>?</u> <u>1916</u> (Month) (Day) (Year)					
7 AGE <u>14</u> yrs. <u>-</u> mos. <u>-</u> ds. If LESS than 1 day ____ hrs. or ____ min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>School boy</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____					
9 BIRTHPLACE (State or country) <u>Md</u>					
PARENTS	10 NAME OF FATHER <u>Wm. Moxley</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Catherine Glover</u>				
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Joe Moxley (uncle)</u> (Address) <u>Rockville Md</u>					
15 Filed <u>June 1st 1923</u> <u>Benj. C. Perry</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>June 1</u> , 19 <u>23</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw <u>the</u> alive on <u>192</u> , and that death occurred on the date stated above, at <u>1 A</u> m. The CAUSE OF DEATH * was as follows: <u>Burns (Accident)</u> <u>Home burned during night while asleep. Cause</u> <u>unknown. Fifth degree burns. Cx. 50.</u> Contributory <u>Supposedly due to electric iron left</u> Secondary <u>connected.</u> (Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds. (Signed) <u>H. J. Press</u> M. D. <u>June 1 1923</u> (Address) <u>Rockville Md</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Mountg Chapel Md.</u>				DATE OF BURIAL <u>June 4, 1923</u>	
20 UNDERTAKER <u>W R Pumphrey Jr</u>				ADDRESS <u>Rockville Md</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, Peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "A trophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 5 1930
BUREAU U. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			06847 STATE OF MARYLAND	
County <u>Montgomery</u>			CERTIFICATE OF DEATH	
Village or City <u>Elkay Echo Park Md</u> (No. <u>178</u>)			Registration Dist. No. <u>216</u>	
2 FULL NAME <u>Gordon Moxley</u>			St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>?</u> <u>?</u> <u>1922</u> (Month) (Day) (Year)				
7 AGE <u>8</u> yrs. <u>?</u> mos. <u>?</u> ds. If LESS than 1 day ____ hrs. or ____ min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>School boy</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Md</u>				
10 NAME OF FATHER <u>William Moxley</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
12 MAIDEN NAME OF MOTHER <u>Catherine Moxley</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Joe Moxley (Uncle)</u>				
(Address) <u>Rockville Md</u>				
15 Filed <u>June 1st 1923</u> <u>Ben C Perry</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>June 1</u> , 192 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>Birth</u> 192 <u>2</u> to <u>1923</u> , 192 <u>2</u> , that I last saw him alive on <u>June 1</u> , 192 <u>2</u> , and that death occurred on the date stated above, at <u>1 P. M.</u> The CAUSE OF DEATH was as follows: <u>Burns (Accident)</u> <u>Home burned during night, while asleep. Cause unknown. Fifth degree Burns. Cuts & scratches.</u>				
Contributory Secondary <u>Supposedly due to electric iron left connected.</u> (Duration) ____ yrs. ____ mos. ____ ds.				
(Signed) <u>H. J. Pratt</u> M. D. <u>June 1 1923</u> (Address) <u>Rockville Md</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)				
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.				
Where was disease contracted, if not at place of death? _____				
Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Montg. Chapel - Md</u>				DATE OF BURIAL <u>June 4 1923</u>
20 UNDERTAKER <u>W. R. Humphrey Jr.</u>				ADDRESS <u>Rockville Md</u>

If more blanks are needed, address State Registrar, 13 W. Saratoga St., Balt., requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plumber, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City rs. Elgettsville (No. _____)

2 FULL NAME Mrs. Virginia Fletcher Moxley

12559

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 211

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH February 7, 1854
(Month) (Day) (Year)

7 AGE 76 yrs. 8 mos. 11 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Thomas Baker

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anne Burton

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray Moxley

(Address) R.D. Mondavia, Md.

15 Filed Oct. 19, 1930 Della O. Beall
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 18, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct. 15, 1930 to Oct. 18, 1930

that I last saw her alive on Oct. 17, 1930

and that death occurred on the date stated above, at 5 a m.

The CAUSE OF DEATH * was as follows:

Cerebral Haemorrhage

Contributory (Duration) ____ yrs. ____ mos. ____ ds. Arterio-Sclerosis
Secondary

(Signed) George M. Boyer M. D.
Oct. 18, 1930 (Address) Darnestown Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Montgomery Chapel Cemetery DATE OF BURIAL Oct. 20, 1930

20 UNDERTAKER Herman Snyder ADDRESS Mt. Airy, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

RECEIVED

NOV 5 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Corneal, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae; Whooping cough; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH <i>Montgomery</i>			113 12560			STATE OF MARYLAND CERTIFICATE OF DEATH		
County <i>Prince Georges</i>			Registration Dist. No. <i>216</i>					
Village or City <i>Beltsville</i>			(No. <i>1</i>)			St. <i>1</i> Ward <i>1</i> (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <i>Mary Ann Mullan</i>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <i>Single</i>						
6 DATE OF BIRTH <i>Aug 30 1930</i> (Month) (Day) (Year)								
7 AGE <i>8 yrs. 26 mos. 26 ds.</i> If LESS than 1 day ____ hrs. or ____ min.?								
8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)			<i>None</i>					
9 BIRTHPLACE (State or country)			<i>MD</i>					
PARENTS	10 NAME OF FATHER <i>Charles E Mullan</i>							
	11 BIRTHPLACE OF FATHER (State or country)			<i>MD</i>				
	12 MAIDEN NAME OF MOTHER <i>MD</i>							
	13 BIRTHPLACE OF MOTHER (State or Country)			<i>MD</i>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE								
(Informant) <i>Mrs. C. E. Mullan</i>								
(Address) <i>Beltsville</i>								
15 Filed <i>1930</i>			192 <i>DR. J. H. K. Porter</i>					
			Registrar					
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <i>Oct. 25, 1930</i> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from <i>Oct 21 1930</i> to <i>Oct 25 1930</i> that I last saw her alive on <i>Oct 23, 1930</i>								
and that death occurred on the date stated above, at <i>4 A</i> m. The CAUSE OF DEATH * was as follows: <i>Acute Indigestion</i>								
Contributory Secondary <i>Acute Indigestion</i> (Duration) ____ yrs. ____ mos. ____ ds.								
(Signed) <i>W. H. P. Mullan</i> M.D. (Address) <i>Beltsville</i>								
*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)								
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.								
Where was disease contracted, if not at place of death?								
Former or Present residence								
19 PLACE OF BURIAL OR REMOVAL <i>MD Ligon</i>						DATE OF BURIAL <i>Oct 27 1930</i>		
20 UNDERTAKER <i>W. H. P. Mullan</i>						ADDRESS <i>Beltsville</i>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not grudgingly employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic; cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as *Asthenia*, "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. S.

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1 PLACE OF DEATH
County *Montgomery*

Village or City *Kensington* (No. _____) St. _____ Ward _____

2 FULL NAME *Josephine Dayton Mulligan*

08171 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. *214*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *W.* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Married*

6 DATE OF BIRTH *about 1878*

(Month) (Day) (Year)

7 AGE *about 52 yrs.*

If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION

- (a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) *Mass*

10 NAME OF FATHER *Chas Dayton*

11 BIRTHPLACE OF FATHER (State or country) *England*

12 MAIDEN NAME OF MOTHER *Mildred*

13 BIRTHPLACE OF MOTHER (State or Country) *England*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Dom Mulligan*

(Address) *Kensington*

15 Filed *July 26 1920* *W. W. Taltavell* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *July 26, 1920*

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from *July 25, 1920* to *July 26, 1920*
that I last saw her alive on *July 26, 1920*

and that death occurred on the date stated above, at *11 P* m.
The CAUSE OF DEATH * was as follows:

Carcinoma of Uterus

(Duration) *3* yrs. ____ mos. ____ ds.

Contributory
Secondary *Carcinoma of Uterus*

(Duration) *3* yrs. ____ mos. ____ ds.

(Signed) *W. L. Lewis* M. D.

July 20, 1920 (Address) *Kensington*

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Kensington D.C.*

DATE OF BURIAL *7/28, 1920*

20 UNDERTAKER *W. W. Taltavell*

ADDRESS *Wash - 24 3019 4th NW*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUR
JUN 7 1920

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

Village or City Olney (No. Mont Co Gen Hosp - St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lee Murphy

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE w. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH July 30th, 1919
(Month) (Day) (Year)

7 AGE 10 yrs. 6 mos. ds. or min. If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work School
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Arlington Murphy

11 BIRTHPLACE OF FATHER (State or country) MO.

12 MAIDEN NAME OF MOTHER Estelle Payman

13 BIRTHPLACE OF MOTHER (State or country) MO.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Estelle Murphy

(Address) Spencerville MO.

15 Filed Jan 28 1930 C. S. Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 28th, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 28th 1930 to Jan 28th, 1930
that I last saw him alive on Jan 27th, 1930

and that death occurred on the date stated above, at 1245 a.m.

The CAUSE OF DEATH * was as follows: Was sledding on State Road, at Spencerville, was struck in his midsection by an automobile, rupturing his spleen. Cerebral

Ruptured spleen
(Duration) yrs. mos. 9 1/2 ds.

Contributory Traumatic pneumonia
Secondary
(Duration) yrs. mos. 2 ds.

(Signed) J. W. B. B. B. M. D.
Jan 28 - 1930 (Address) Sandy Spring MD

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. 3 1/2 In the life State yrs. mos. ds.

Where was disease contracted at former residence if not at place of death?

Former or usual residence Spencerville MO.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Union Cem. Burtonville MO Jan 30th, 1930

20 UNDERTAKER ADDRESS

Clwood M. Fisher - Laurel MO.

per issued.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 5 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Takoma Park (No. 416 Hancock Ave

2 FULL NAME

Daniel Raitt Neall

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
OR-DIVORCED
(Write the word)

6 DATE OF BIRTH

Sept 22nd, 1932
(Month) (Day) (Year)

7 AGE

78 yrs. 2 mos. 23 ds. or min.?
If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Elliott Maine

10 NAME OF FATHER

John Neall

11 BIRTHPLACE OF FATHER

(State or country)

Elliott Maine

12 MAIDEN NAME OF MOTHER

Elizabeth Raitt

13 BIRTHPLACE OF MOTHER

(State or country)

Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs D R Neall

(Address)

416 Hancock Ave

15

Filed

Dec 15 1930

H. E. Rogers

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 10th, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from Dec 10th 1930 to Dec 10th 1930.that I last saw him alive on Dec 10th 1930.

and that death occurred on the date stated above, at 10 m.

The CAUSE OF DEATH * was as follows:

Myocarditis

Contributory
Secondary(Duration) 3 yrs. 1 mos. 1 ds.
Degenerative Disturbance
High Blood Pressure

(Signed)

Dorinda E. Kees M. D.
Dec 15 1930 (Address) Takoma Park Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash D C

12/16, 1930

20 UNDERTAKER

ADDRESS

Thos S. Surgeon 1011-7th NW

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plunker, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 3 1931
BUREAU

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1 PLACE OF DEATH

County

Mulgoing

Village or City

Germantown

(No. _____)

2 FULL NAME

Beyamine Franklin Newma

10553

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *2/3*

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Wego

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

April 10 1864
(Month) (Day) (Year)

7 AGE

66 yrs. 4 mos. 23 ds.
If LESS than 1 day hrs. or min.?

OCCUPATION

(a) Trade, profession or particular kind of work

Day laborer in farm

(b) General nature of industry business, or establishment in which employed or (employer)

Farming

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Lizzie Helman

13 BIRTHPLACE OF MOTHER

(State or country)

Friedrich City Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ames Edward Newma

(Address)

1217 Irving St. Hagley

15

Filed

*9/6/1930**up**2 years 11 mos. 2 days*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sep. 3-2 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *Jan 12 1930* to *Sept 3 1930*.
that I last saw him alive on *Sept 2 1930*.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows

*Myocardial degeneration
Subacute Myocarditis*(Duration) *1 yrs. 6 mos. - ds.*Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) *Lipton Droumel* M. D.
9/6/1930 (Address) *Danville Va*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brownstown, Calverton, Sep. 6 1930

20 UNDERTAKER

Ruben Purphey Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT 4 1930
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

04470

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218Village or City Leptonsville (No. 444)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Chas W Newman

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH January 30, 1872
(Month) (Day) (Year)

7 AGE 58 yrs. 2 mos. 27 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry business, or establishment in which employed or (employer) Labor

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Albert Newman

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Burke

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas W Newman(Address) Leptonsville

15 Filed April 30 1930 W. H. Dyson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April - 27 - 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 4/24/30 192 to 4/27/30 192, that I last saw him alive on 4/27/30 192,

and that death occurred on the date stated above, at 2 p. m.
The CAUSE OF DEATH * was as follows:

Lobar Pneumonia

Contributory (Duration) ____ yrs. ____ mos. ____ ds.
Secondary Pulmonary Edema

(Signed) Chas. L. Smith M. D.
4/29/30 (Address) Leptonsville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MT Zion Church April 30, 1930

20 UNDERTAKER

ADDRESS

Roy W Barber Leptonsville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH
County Frederick Montg

Village or City Dickerson (No.)

FULL NAME Franklin P. Nickols

12561 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. 2 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Unknown 1 (Month) (Day) (Year)

7 AGE 75 yrs. mos. ds. or min. If LESS than 1 day hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Labor (b) General nature of industry business, or establishment in which employed or (employer) —

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER William H. Nickols

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie E. Taylor

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Raphael A. Nickols (Address) Dickerson

15 Filed Oct 6 1930 Mrs. C. C. Hilton Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 3rd 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192... to 192...

that I last saw him alive on Oct 3rd 19230

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH * was as follows:

Accidental gunshot wound -

Contributory Secondary

(Signed) F. P. Nickols M. D. (Address) Dickerson (Duration) yrs. mos. ds.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL M. E. Ch. Poolestrach DATE OF BURIAL Oct 6 - 1930

20 UNDERTAKER W. T. Hilton & Sons ADDRESS Barnesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Pea-ler," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 23 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphena," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate be permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Rockville (No. _____)

2 FULL NAME Leonard S. Nicholson

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 243

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH Oct. 1, 1843
(Month) (Day) (Year)

7 AGE 87 yrs. 1 mos. 20 ds. If LESS than 1 day _____ hrs. or _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed or (employer) Army Officer

9 BIRTHPLACE (State or country) Washington D.C.

10 NAME OF FATHER A. S. Nicholson

11 BIRTHPLACE OF FATHER (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or Country) New York

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. S. Nicholson Jr.

(Address) Rockville Md.

15 Filed Jan 22 1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 21, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 6, 1930 to Jan. 21, 1930, that I last saw him alive on Jan. 21, 1930, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH * was as follows:

Myocarditis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary Arterio-sclerosis

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. V. Hatten M. D.

Jan. 22, 1930 (Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rock Creek Washgton Jan. 23, 1930

20 UNDERTAKER ADDRESS

Harmon C. Humphrey Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data are essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 6 1900

BUT

MARGIN RESERVED FOR BINDING
WRITE MAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH
County MontgomeryVillage or City Cherry Chase Gardens2 FULL NAME Leonard S. Nicholson03111
(90)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)6 DATE OF BIRTH Unknown 1
(Month) (Day) (Year)7 AGE 75 yrs. mos. ds. or min. If LESS than 1 day hrs.OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed or (employer)Physician9 BIRTHPLACE
(State or country)Ontario

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Hilda Nicholson
Bethesda Md.15 Filed Mar 5 1930 Benj. C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 5, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Dead when first seen to 1930
that I last saw him alive on 1930and that death occurred on the date stated above, at m.
The CAUSE OF DEATH * was as follows:Cerebral EmbolismContributory
SecondaryChr. Valvular Heart Disease
(Duration) yrs. mos. ds.(Signed) E. G. B. Bousfield M. D.
Mar 5-30 (Address) Bethesda Md
(Duration) yrs. mos. ds.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D.C. Mar. 8, 1930

20 UNDERTAKER

ADDRESS

The S. H. Hiner Co Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

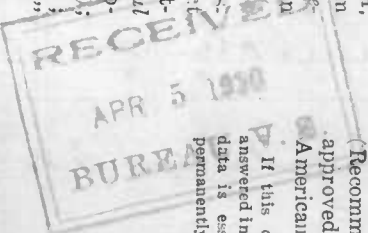
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACS should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

Village or City Buck Lodge St. 202 Ward 2 (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME Raymond Lee Peterson Nicholson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH 3 10th 1927 (Month) (Day) (Year)

7 AGE 3 yrs. 9 mos. 28 ds. or min.?

8 OCCUPATION (a) Trade, profession or particular kind of work at home (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Montg. Co Md

10 NAME OF FATHER Wm. M. Nicholson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Ellis

13 BIRTHPLACE OF MOTHER (State or country) Washington DC

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant Annie E. Nicholson (Address Buck Lodge Md)

15 Filed Dec 11 - 1930 more Hill Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 10th 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased not 1930, but 1927 that I last saw him alive on Dec 10th 1920

and that death occurred on the date stated above, at 11 1/2 m.

The CAUSE OF DEATH * was as follows:
Accidental suffocation
foreign body in larynx
(block of throat)
for removal
(Duration) yrs. mos. ds.

Contributory Disordered circulation
Secondary hypertrophy
(Duration) yrs. mos. ds.

(Signed) John A. Brown M. D.
12/10/30 (Address) Sarverville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Burke Md. DATE OF BURIAL 12/12/30

20 UNDERTAKER H. J. Hallin Son ADDRESS Barnville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

*This should be returned
under the heading of a report
The paper was written in
Germany or Sweden on part
number 10 years (should be long
and broken) - I feel sure
that it is also delayed
apt death!
H. W. M. D.*

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Coreioma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile", etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931

BUREAU

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>			13924		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>W. Cedar Grove</u> (No. _____)			(129)		Registration Dist. No. <u>211</u>	
2 FULL NAME <u>Rubin Mortimer Nicholson</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>				
6 DATE OF BIRTH <u>May 12</u> , 18 <u>53</u> (Month) (Day) (Year)						
7 AGE <u>77</u> yrs. <u>4</u> mos. <u>3</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired Farmer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Md.</u>						
10 NAME OF FATHER <u>James Nicholson</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>						
12 MAIDEN NAME OF MOTHER <u>Lydia Andrews</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs R. M. Nicholson</u> (Address) <u>P. D. Gaithersburg, Md.</u>						
15 Filed <u>Nov. 16</u> , 19 <u>30</u> <u>Della W. Beall</u> Deft. Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Nov 15</u> , 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>July 13</u> , 19 <u>26</u> to <u>Nov. 15</u> , 19 <u>30</u> , that I last saw him alive on <u>Nov 13</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>4 a</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic Interstitial Ne- phritis</u>						
more than <u>5</u> yrs. mos. ds. (Duration) <u>Arterio Sclerosis</u>						
Contributory Secondary (Duration) yrs. mos. ds. (Signed) <u>George M. Boyer</u> M. D. <u>Nov 15</u> , 19 <u>30</u> (Address) <u>Damascus Md.</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Babin Cemetery Cedar Grove Md.</u>					DATE OF BURIAL <u>Nov 16</u> , 19 <u>30</u>	
20 UNDERTAKER <u>J. B. Beall, Inc.</u>					ADDRESS <u>Damascus Md.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

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PLACE OF DEATH

County

Village or City

No.

FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

Feb 25 1930

J. E. Whelshy
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory Secondary

(Signed) M. D.

Feb 25 1930 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Woman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as, *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

08172

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213Village or City Rockville (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Ferdinand J. Nugent Jr.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Jan 19, 1910
(Month) (Day) (Year)

7 AGE 21 yrs. 6 mos. 12 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Ferdinand J. Nugent Sr.

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Emma Cook

13 BIRTHPLACE OF MOTHER (State or Country) D C

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Nugent

(Address) Rockville Ind

15 Filed 8/2 1930 Mrs. W. T. Pratt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 31, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended the deceased from 5/14 1929 to 7/31 1930

that I last saw him alive on 7/31 1930

and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH * was as follows:

Chronic Pulmonary Tuberculosis

(Duration) 5 yrs. ____ mos. ____ ds.

Contributory Tuberculosis of knee

(Duration) 20 yrs. ____ mos. ____ ds.

(Signed) C. S. J. Smith M. D.

192 ____ (Address) Rockville Ind

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville Ind

DATE OF BURIAL 8-3, 1930

20 UNDERTAKER Leo R. Brown

ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

RECEIVED

AUG 6 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

13925

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 2-13

Village or City

Takoma Park

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Arvi A. NuemiAutopsy at Rockville

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Single

6 DATE OF BIRTH

July 10, 1906
(Month) (Day) (Year)

7 AGE

24 yrs. 5 mos. 9 ds. or min.

If LESS than 1 day ____ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed or (employer)

U.S. Govt.

9 BIRTHPLACE

(State or country)

New York

10 NAME OF FATHER

Andrew S. Nuemi

11 BIRTHPLACE OF FATHER

(State or country)

Finland

12 MAIDEN NAME OF MOTHER

Mary S. Dahl

13 BIRTHPLACE OF MOTHER

(State or Country)

Finland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Andrew S. Nuemi

(Address)

See

15

Filed 11/221936Mrs. W. T. Pratt

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 19, 1936
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

acted as coroner at the request of the deceased
that I last saw him alive on Nov 19, 1936

and that death occurred on the date stated above, at ____ m.

The CAUSE OF DEATH * was as follows:

Guns shot wound
Homicidal. C. & R.

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) John Jones Coroner M. D.
11-22-1936 (Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.

In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fort Lincoln Cemetery Nov. 22, 1936

20 UNDERTAKER

ADDRESS

Warner E. Humphrey Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 2 1930

BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

09391

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Cherry Chase (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary M. O'Callaghan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)
7 AGE 56 yrs. - mos. - ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) County Cork, Ireland

PARENTS
10 NAME OF FATHER Daniel O'Callaghan
11 BIRTHPLACE OF FATHER (State or country) Ireland
12 MAIDEN NAME OF MOTHER Margaret Sullivan
13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. J. Callaghan(Address) Cherry Chase, Md15 Filed Aug 12, 1911 Benj. C. Perry

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 11th, 1980.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him dead when first seen, and that death occurred on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH * was as follows:

Drowning - Accidental.

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Signed) E. G. Bowers (Duration) ____ yrs. ____ mos. ____ ds.
Aug. 12, 1911 (Address) Bethesda Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds.
Where was disease contracted, If not at place of death ?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Forest Glen Cemetery Md DATE OF BURIAL Aug 14, 1911
20 UNDERTAKER J. J. Clements Sons ADDRESS Washington, D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired) J. J. S.*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonoeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite, avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Athensia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
SEP 3 1900
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE ONLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

09392
(145-C)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Lakewood Park (No. Washington San Hosp. Md. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs Florence Olson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Caucasian</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>July 10 1898</u> (Month) (Day) (Year)		
7 AGE <u>32 yrs. 1 mos. 5 ds.</u> or <u>min.?</u> If LESS than 1 day hrs.		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Nurse in Dental Office</u> (b) General nature of industry, business, or establishment in which employed or (employer)		
9 BIRTHPLACE (State or country) <u>Washington, D.C.</u>		
10 NAME OF FATHER <u>Isaac Porter</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>Washington, Pa</u>		
12 MAIDEN NAME OF MOTHER <u>?</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>St Louis, Mo</u>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington Sanitarium Records
(Address) Lakewood Park, Md.

15 Filed Aug 15 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>Aug 15 1930</u> (Month) (Day) (Year)	17 I HEREBY CERTIFY, That I attended the deceased from <u>Aug 14 1930</u> to <u>Aug 15 1930</u> , that I last saw him alive on <u>Aug 15 1930</u> , and that death occurred on the date stated above, at <u>3:10 p.m.</u> The CAUSE OF DEATH * was as follows: <u>Rupture of uterus</u> (Duration) yrs. mos. <u>2</u> ds. Contributory <u>Pregnancy</u> Secondary (Duration) yrs. <u>3</u> mos. <u>1</u> ds. (Signed) <u>W. H. Mitchell</u> M. D. <u>Aug 15 1930</u> (Address) <u>Silver Spring, Md.</u>
18 STATE THE DISEASE CAUSING DEATH, OR, IN DEATH FROM VIOLENT CAUSES, STATE (1) MEANS OF INJURY AND (2) WHETHER ACCIDENTAL, SUICIDAL OR HOMICIDAL.	

19 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence.	In the State yrs. mos. ds.
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19 PLACE OF BURIAL OR REMOVAL <u>Wash. D.C.</u>	DATE OF BURIAL <u>Aug 18 1930</u>
20 UNDERTAKER <u>W.W. Deal Co</u>	ADDRESS <u>816-H St. N.E.</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by rolling train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. Aithed data is essential and must be obtained before the certificate is permanently filed.

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Montgomery

04471

STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 217

 Village or City Berksville (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

² FULL NAME Thomas Sewell Cindoff

PERSONAL AND STATISTICAL PARTICULARS

 3 SEX M. 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

 6 DATE OF BIRTH 10-26-1854
(Month) (Day) (Year)

 7 AGE 75 yrs. 5 mos. 13 ds. or LESS than 1 day ____ hrs. ____ min.

 8 OCCUPATION
(a) Trade, profession or particular kind of work Cigar Business
(b) General nature of industry business, or establishment in which employed (or employer) _____

 9 BIRTHPLACE (State or country) Md.

 10 NAME OF FATHER William Cindoff

 11 BIRTHPLACE OF FATHER (State or country) Md.

 12 MAIDEN NAME OF MOTHER Susan Adams

 13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) Walter C. Parker

 (Address) Berksville Md

 15 Filed April 13 1930 C. S. Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH 4/9/1930
(Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended the deceased from 4/1/1924 to 4/9/1930, that I last saw him alive on 4/9/1930,

 and that death occurred on the date stated above, at 4 P m. The CAUSE OF DEATH * was as follows:

Chronic Interstitial Nephritis
(Duration) 6 yrs. ____ mos. ____ ds.

 Contributory Secondary Uremia
(Duration) ____ yrs. ____ mos. 4 ds.

 (Signed) W. C. Parker M. D.
4/9/1930 (Address) Sandy Spring

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rockville 4/12/1930

20 UNDERTAKER ADDRESS

Harner & Humphrey Rockville

for issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plunker, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrub, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *septica, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Montg.

Village or City

Neal Doback (No. _____)

2 FULL NAME

John Samuel Orrison

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

widow

6 DATE OF BIRTH

Feb. 13, 1844
(Month) (Day) (Year)

7 AGE

83 yrs. 0 mos. 12 ds. or min.?

IF LESS than
1 day ____ hrs.
or ____ min.?

8 OCCUPATION

(a) Trade, profession or
particular kind of work

farmer

(b) General nature of industry
business, or establishment in
which employed or (employer)9 BIRTHPLACE
(State or country)

Virginia

10 NAME OF
FATHER

John S. Orrison

11 BIRTHPLACE
OF FATHER
(State or country)

Virginia

12 MAIDEN NAME
OF MOTHER

unknown

13 BIRTHPLACE
OF MOTHER
(State or Country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mr. Wilbur Orrison
Doback-Maryland

15

Filed 2-26-1933 Mrs. W. T. Pratt
Registrar

01823

(90)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____

(If death occurred in
a hospital or institution,
give its NAME instead of
street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

February 24, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Feb. 15, 1930, to Feb. 24, 1930,

that I last saw him alive on Feb. 24, 1930,

and that death occurred on the date stated above, at 5:10 P. M.

The CAUSE OF DEATH * was as follows:

Mitral Regurgitation

Contributory
Secondary

unknown (Duration) ____ yrs. ____ mos. ____ ds.

Chronic rheumatism

(Signed) G. A. Hartley M. D.

Feb. 26, 1930 (Address) Rockville

*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenwood Cem. Wash. DC 2/27/30

20 UNDERTAKER

W. R. Humphrey Jr. Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
MAR 8 1930
BU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		01824		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Gaithersburg</u> (No. <u> </u>)		160		Registration Dist. No. <u>218</u>	
2 FULL NAME <u>Infant Overholtz</u>		St. <u> </u> Ward <u> </u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)			
6 DATE OF BIRTH <u>12 Jan 1930</u> (Month) (Day) (Year)					
7 AGE <u>0</u> yrs. <u>0</u> mos. <u>21</u> ds. or min. If LESS than 1 day hrs. min.					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>none</u>					
9 BIRTHPLACE (State or country) <u>Mo.</u>					
PARENTS	10 NAME OF FATHER <u>Frank Overholtz</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u>				
	12 MAIDEN NAME OF MOTHER <u>Goldie Smith</u>				
13 BIRTHPLACE OF MOTHER (State or Country) <u>Va.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Frank Overholtz</u> (Address) <u>Gaithersburg Md.</u>					
15 Filed <u>Feb 2 1930</u> <u>Boeldene Etelson</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>2 Feb 1930</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 1930</u> to <u>2 Feb 1930</u> , that I last saw him alive on <u>17 Feb 1930</u> , and that death occurred on the date stated above, at <u>130a</u> m. The CAUSE OF DEATH was as follows: <u>congenital debility</u> (Duration) <u>21</u> yrs. mos. ds.					
Contributory Secondary (Duration) <u> </u> yrs. mos. ds.					
(Signed) <u>Stanley W. B. Parker</u> M.D. <u>2130 Gaithersburg</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>21</u> yrs. mos. ds. In the State <u>same</u> yrs. mos. ds. Where was disease contracted, if not at place of death? <u>same</u> Former or usual residence <u>same</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Town Brook</u> DATE OF BURIAL <u>30</u>					
20 UNDERTAKER <u>E. C. Jarrett</u> ADDRESS <u>Gaithersburg</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Soleismen*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Printer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Group"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—occident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

MAR 7 1930

BUREAU V. S.

WRITE IN INK ONLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montg.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 211Village or City Clarksburg

(No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME James Edward Page

PERSONAL AND STATISTICAL PARTICULARS

3 SEX
Male4 COLOR OR RACE
White5 SINGLE,
MARRIED, Married
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Oct. 141844

(Month)

(Day)

(Year)

7 AGE

86

yrs.

3

mos.

7

ds.

or min.?

If LESS than
1 day ____ hrs.

8 OCCUPATION

(a) Trade, profession or
particular kind of workLaborer(b) General nature of industry
business, or establishment in
which employed or (employer)

9 BIRTHPLACE

(State or country)

Montgomery Co., Md.10 NAME OF
FATHERUnknown11 BIRTHPLACE
OF FATHER

(State or country)

Unknown12 MAIDEN NAME
OF MOTHERUnknown13 BIRTHPLACE
OF MOTHER

(State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roland Page

(Address)

Clarksburg, Md.

15

Filed

Jan. 2219230W. E. Lewis
Local

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1.....211930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1....211930to 1....211930that I last saw him in bed on 1.....21, 1930.and that death occurred on the date stated above, at 12:15A m.

The CAUSE OF DEATH * was as follows:

Myocardial Degeneration.Contributory
SecondarySenility(Duration) 0 yrs. 6 mos. 0 ds.

(Signed)

William D. Smith

M. D.

2-19-30

(Address)

Gaithersburg, Md.*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place
of death ____ yrs. ____ mos. ____ ds.In the
State ____ yrs. ____ mos. ____ ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Clarksburg, Md.Jan. 23, 1930

20 UNDERTAKER

ADDRESS

W. V. Bennett & SonHyattsville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

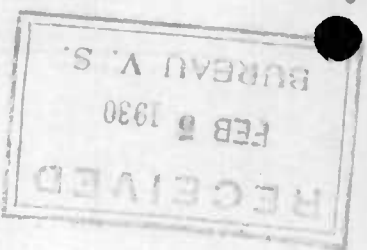
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montg

04472

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

Village or City

Providence No.

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Chas Harrison Palmer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Colored

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Apr 26, 1927
(Month) (Day) (Year)

7 AGE

3 yrs. 11 mos. 13 ds. or min.?

If LESS than

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF

FATHER

Uthama Palmer

11 BIRTHPLACE

OF FATHER

(State or country)

Md

12 MAIDEN NAME

OF MOTHER

Carrie Palmer

13 BIRTHPLACE

OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Carrie Palmer

(Address)

Providence

15

Filed

Apr 15, 1930 E. W. White

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 13, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

No physician in 1927 to 1930
that I last saw him alive on Oct 1, 1927

and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH * was as follows:

Congenital
Hydrocephalus

(Duration) 2 yrs. 11 mos. 13 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

E. W. White

M. D.

Apr 15, 1930 (Address) Providence

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Morningsburg

4/15, 1930

20 UNDERTAKER

ADDRESS

Henry Davis

Providence

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Chronic pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1930
BUREAU OF

N. 2. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) M. D.

Mar 5 1930 (Address)

*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Fisherman, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 4 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Kinsington (No. _____)

2 FULL NAME Emily Ann Parker

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Aug 15, 1847
(Month) (Day) (Year)

7 AGE 82 yrs. 5 mos. 16 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Mass.

10 NAME OF FATHER Jno D. Goodwin

11 BIRTHPLACE OF FATHER (State or country) Mass.

12 MAIDEN NAME OF MOTHER Mary A. Tuttle

13 BIRTHPLACE OF MOTHER (State or Country) Mass.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Parker

(Address) Kinsington

15 Filed Jan 1, 1930 W. L. Lewis
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 1, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from July 1, 1928 to Jan 1, 1930
that I last saw him alive on Jan 1, 1930

and that death occurred on the date stated above, at 10:15 A.m.
The CAUSE OF DEATH * was as follows:

Carcinoma of Uterus

(Duration) 18 mos. ____ ds.

Contributory Secondary Exhaustion

(Duration) 15 ds.

(Signed) W. L. Lewis M. D.
Jan 1, 1930 (Address) Kinsington

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville

DATE OF BURIAL Jan 2, 1930

20 UNDERTAKER Warner Pumphrey ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

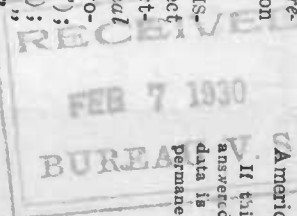
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (c) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

Village or City Rockville (No. _____)

2 FULL NAME Lillie Parker

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE owl 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH unknown, 1900
(Month) (Day) (Year)

7 AGE 30 yrs. 30 mos. 30 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work House work.
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Peter Robinson

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Lana Cockett

13 BIRTHPLACE OF MOTHER (State or Country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jennie Deffen
(Address) Rockville Md

15 Filed 12-9 1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec - 4, 19230
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 10/2 19230 to 12/6 19230
that I last saw her alive on Dec 4, 19230

and that death occurred on the date stated above, at ____ m.
The CAUSE OF DEATH * was as follows:

Carcinoma of Intestines

(Duration) 2 yrs. ____ mos. ____ ds.

Contributory Secondary none

(Signed) C. E. Hawks M. D.
12-9 19230 (Address) Rockville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville md DATE OF BURIAL 12-9, 1930

20 UNDERTAKER Geo R. Monden ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

0361 21 DEC

CITY AND COUNTY

MARGIN RESERVED FOR BINDING
WRITE IN PENCIL WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Bethesda

2 FULL NAME John William Parsley

13926
90

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 5-31-1896
(Month) (Day) (Year)

7 AGE 94 yrs. 5 mos. 21 ds. If LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER William H. Parsley

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Ray

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Bayan
(Address) Bethesda Md.

15 Filed Nov 25 1933 C. S. Carneley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 / 22 / 1938
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 11 / 22 / 1938 to 11 / 22 / 1938
that I last saw him alive on 11 / 22 / 1938

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:
Chronic Myocarditis

(Duration) yrs. 3 mos. ____ ds.

Contributory Secondary Acute Detention of Heart
(Duration) yrs. ____ mos. ____ ds.

(Signed) J. M. B. M. D.
11 / 22 / 1938 (Address) Sandy Spring

*state the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Union Cemetery, Bethesda, Md. DATE OF BURIAL Nov 25, 1938

20 UNDERTAKER Lloyd Kaiser ADDRESS Laurel Md.

For issuance of birth and death certificates, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Formerly-retired 6 yrs*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Leber pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 3 1930
BUREAU V. B.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Montgomery

Village or City

Takoma Park

(No.

Wash. San. Ed. Hosp.

Ward)

Registration Dist. No.

2273

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John McEwen Paterson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

March

18

1930

(Month)

(Day)

(Year)

7 AGE

Stillborn

If LESS than 1 day... hrs. yrs. mos. ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employee)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Andrew T. Paterson

11 BIRTHPLACE OF FATHER

(State or country)

Scotland

12 MAIDEN NAME OF MOTHER

Terese McEwen

13 BIRTHPLACE OF MOTHER

(State or country)

Scotland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Terese McEwen Paterson

(Address)

4234 8th St. N.W. Wash. D.C.

15

Filed

Mar 18 1930

H. E. Logan

Registrar

03112

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 18

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

at birth 192.

to March 18, 1930

that I last saw him alive on

still born

192.

and that death occurred on the date stated above, at 1:07 A.M.

The CAUSE OF DEATH * was as follows:

Intra uterine asphyxia

(Duration)

yrs.

mos. 1-2 hrs.

Contributory
Secondary

uterine inertia

(Duration)

yrs.

mos. 1-2 hrs.

(Signed)

D. E. Ravenport

M. D.

March 18, 1930

(Address)

Wash. San. Ed. Hosp. Takoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

Barn there

In the State

Barn in Md.

Where was disease contracted, if not at place of death

Parents Residence

48th St. N.W. Wash. D.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cebauter, Md

Mar 18, 1930

20 UNDERTAKER

W. W. Daltmire

ADDRESS

3619-14th N.W.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic uterular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little data is essential and must be obtained before the certificate is permanently filed.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rochet wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A, the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1930

BUREAU OF

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

Village or City

Bethesda

(No. _____)

41st and Western Ave

Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mary Ann Payton

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Oct.

13

1849

(Month)

(Day)

(Year)

7 AGE

81

yrs. —

mos. —

ds. —

IF LESS than
1 day ____ hrs.
or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

D.C.

10 NAME OF
FATHER

William Goodrich

11 BIRTHPLACE

OF FATHER

(State or country)

Va

12 MAIDEN NAME

OF MOTHER

Rebecca Huddle

13 BIRTHPLACE

OF MOTHER

(State or Country)

D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

H. M. Smith

(Address)

4001 - Van Ness St NW

15

Filed

Oct. 15 1930

Thos. K. Conrad

Registrar

Chevy Chase

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

October 15

1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from
Sept 1 1930 to October 15 1930
that I last saw him alive on October 14 1930and that death occurred on the date stated above, at 8:30 p.m.
The CAUSE OF DEATH * was as follows:Cardio vascular renal
disease (Duration) 1 yr. 2 mos. 20 daysContributory
Secondary

Smoking

(Signed) J. H. Smith, M. D.
Oct 16 1930 (Address) 4448 Grant Way

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.

In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Methodist Cemetery Wash. D.C.

DATE OF BURIAL

Oct. 17, 1930

20 UNDERTAKER

L. H. Wise Co.

ADDRESS

2900 - M N.W. WASH. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 6 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Bethesda (No. _____)

2 FULL NAME William T. Payton

13928

100-0

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 216

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH July 7, 1849
(Month) (Day) (Year)

7 AGE 81 yrs. 3 mos. 25 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) D.C.

10 NAME OF FATHER Jos. Payton

11 BIRTHPLACE OF FATHER (State or country) D.C.

12 MAIDEN NAME OF MOTHER King

13 BIRTHPLACE OF MOTHER (State or Country) D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. M. Smith
(Address) 4001 Wisconsin St.

15 Filed Nov. 3, 1930 Benj. C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 3rd, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from October 27, 1929 to November 1, 1930

that I last saw him alive on November 1, 1930

and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH * was as follows:

Pneumonia, Broncho. Cong.
(Duration) ____ yrs. ____ mos. 5 ds.

Contributory Secondary arterio-sclerosis
(Duration) 3 yrs. ____ mos. ____ ds.
(Signed) J. W. Chappell M. D.
Nov 3, 1930 (Address) 14448 Grandview

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Wash. D.C. DATE OF BURIAL Nov. 4, 1930

20 UNDERTAKER Geo. McKie Co ADDRESS Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the IHS-
EASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
NOV 6 1900
BUREAU

MARGIN RESERVED FOR BINDING

V S No. 1

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Bethesda (No. 401 River Road St. 742 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

2 FULL NAME Thomas S. Perry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Dec. 27th 1860
(Month) (Day) (Year)

7 AGE 69 yrs. 11 mos. 24 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER C. E. Perry

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Summers

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Wm Shoemaker
(Address) Bethesda, Md.

15 Filed Dec 23 1930 Bert C Perry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 21, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from dead when first seen, 192____, that I last saw him alive on, 192____,

and that death occurred on the date stated above, at ____ m. The CAUSE OF DEATH * was as follows:

Central embolism
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) E. G. Bauerfeld M. D.
Dec. 21, 1930 (Address) Bethesda, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Washington DC DATE OF BURIAL 12-24/30

20 UNDERTAKER Geo W White Co ADDRESS Wash. DC

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum, etc., Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 6 1931

BUREAU

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1 PLACE OF DEATH

County

Montg.

15172

(74-a)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

Village or City

Kensington

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Philip Norman Veltri

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

July 6, 1894

(Month)

(Day)

(Year)

7 AGE

36 yrs. 5 mos. 6 ds.

If LESS than
1 day.....hrs.
or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Chemist

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

George Veltri

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Laura Magruder

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Veltri

(Address)

Kensington Md

15

Filed 12/12/30 192

W. M. L. Lewis

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 11, 1923

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Dec 8, 1923 to Dec 11, 1923

that I last saw him alive on Dec 10, 1923

and that death occurred on the date stated above, at 2:15

The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage

(Duration)

Dec 11, 1923

Contributory
Secondary

Cerebral Hemorrhage

(Duration)

Dec 11, 1923

(Signed)

Dec 11, 1923

(Address)

Kensington, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds.

In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rock Creek Sem. Wash DC

Dec 13, 1923

20 UNDERTAKER

ADDRESS

Wm. Henry Humphrey

Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

On this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 5 1931

BUREAU

MARGIN RESERVED FOR BINDING
WRITE HERE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			12563		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgomery</u>			Registration Dist. No. <u>2118</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number.)	
Village or City <u>Gaithersburg</u> No. _____			St. _____ Ward _____			
2 FULL NAME <u>George A. Phoebe</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>				
6 DATE OF BIRTH <u>Nov - 6</u> , 18 <u>89</u> (Month) (Day) (Year)						
7 AGE <u>80</u> yrs. <u>11</u> mos. <u>5</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired Laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>MD</u>						
10 NAME OF FATHER <u>John Phoebe</u>						
11 BIRTHPLACE OF FATHER <u>MD</u>						
12 MAIDEN NAME OF MOTHER <u>Elizabeth Ellis</u>						
13 BIRTHPLACE OF MOTHER <u>MD</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Geo A. Phoebe</u> (Address) <u>Gaithersburg</u>						
15 Filed <u>Oct. 13</u> 19 <u>30</u> <u>Michael Hare Ellison</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>10 - 11 - 1930</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>July - 28</u> 19 <u>30</u> to <u>Oct - 11</u> 19 <u>30</u> , that I last saw him alive on <u>Sept - 28</u> 19 <u>30</u> , and that death occurred on the date stated above, at <u>5-P</u> m. The CAUSE OF DEATH* was as follows: <u>Cerebral hemorrhage</u>						
Contributory Secondary <u>Arterio Sclerosis</u> (Duration) <u>6</u> yrs. <u>0</u> mos. <u>0</u> ds.						
(Signed) <u>W. C. Miller</u> M. D. <u>10-13</u> 19 <u>30</u> (Address) <u>Gaithersburg, MD</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Gaithersburg</u>					DATE OF BURIAL <u>Oct 14</u> 19 <u>30</u>	
20 UNDERTAKER <u>G. C. Gaiter</u>					ADDRESS <u>Gaithersburg</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

RECEIVED

NOV 6 1900

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

03114

(100-a)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217Village or City Brookville (No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Beverly Phoenix

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Negro

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

March 261852

(Month)

(Day)

(Year)

7 AGE

78 yrs.1 mos.0 ds.

If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Farm Hand & Gardener(b) General nature of industry business, or establishment in which employed or (employer) Corned Place

9 BIRTHPLACE

(State or country)

Loudoun Co

10 NAME OF FATHER

Beverly Phoenix

11 BIRTHPLACE OF FATHER

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Virginia (not known)

13 BIRTHPLACE OF MOTHER

(State or Country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

G. M. Sedinger

(Address)

Brookville Md

15

Filed Mar 29 1923C. Barnsley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 261930March

(Month)

26 (Day)1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

1909192

to

March 261930that I last saw him alive on March 26, 1930.and that death occurred on the date stated above, at 5- P.m.

The CAUSE OF DEATH * was as follows:

Bronchial PneumoniaContributory
Secondary

(Duration)

3 yrs.0 mos.0 ds.(Signed) G. M. Sedinger

M. D.

March 26 1930

(Address)

Brookville Md

*State the Illness Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.

In the

State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Sandy Spring

DATE OF BURIAL

3-29, 1930

20 UNDERTAKER

Des R. Brown

ADDRESS

Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

per issuedma

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Drapsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Fiber Springs (No. _____)

2 FULL NAME Mrs Sarah Fannie Pitt

04473 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2-14

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH March 1st, 1860
(Month) (Day) (Year)

7 AGE 70 yrs. 1 mos. 10 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Home work.
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Va

10 NAME OF FATHER Albert L Minor

11 BIRTHPLACE OF FATHER (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah F Minor

13 BIRTHPLACE OF MOTHER (State or Country) Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucian Hawland
(Address) Fiber Springs, Md.

15 Filed April 10 1930 J. E. Wondery Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 10, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 15 1923 to April 10, 1930.
that I last saw him alive on April 9, 1930.
and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH * was as follows:

Acute Dilatation of heart

(Duration) ____ yrs. ____ mos. 1 ds.
Contributory Myocarditis
Secondary (Duration) 10 yrs. 0 mos. 0 ds.

(Signed) W. B. Hagner M. D.
April 10 1930 (Address) Fiber Springs, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Washington, D. C. DATE OF BURIAL Apr 10, 1930

20 UNDERTAKER Martin Hagan Co ADDRESS 1300 N. ST. N.W.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner* (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 9 1930
BUREAU V. S.

MARGIN RESERVED FOR BINDING
WRITE HERE WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Montgomery

03115

(90)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City

Takoma Park (No. 55 Elm Ave -

St.:

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Caroline Elizabeth Pixley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

September 17th, 1848
(Month) (Day) (Year)

7 AGE

81 yrs. 6 mos. 9 ds. or min.?

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work.

none.

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Brilliant Ohio

10 NAME OF FATHER

James Long

11 BIRTHPLACE OF FATHER

(State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Mary Brandon

13 BIRTHPLACE OF MOTHER

(State or Country)

Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs Nellie Acton

(Address)

55 Elm Ave.

15

Filed

March 26

1920

H. B. Harris

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 26th, 1920

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

August 3

1927

to

March 26

1920.

that I last saw him alive on March 26th, 1920.

and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH * was as follows:

Myocarditis

Contributory
Secondary(Duration) 3 yrs. mos. ds.
old age. Arterio Sclerosis

(Signed)

Lauretta E. Kress

M. D.

March 26

1920

(Address)

Takoma Park Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Washington DC

DATE OF BURIAL

March 28, 1920

20 UNDERTAKER

H. B. Harris

ADDRESS

Gt N. Y Ave. Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 3 1930

RECEIVED

N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St.; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,

MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day....hrs.

.....yrs.....mos.....9.....da.or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

193

M. C. C. Hillon
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Contributory
Secondary

(Signed) T. P. Gungl M. D.

Jan. 20, 1930 (Address) Barnesville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Boyd

Jan 21, 1930

20 UNDERTAKER

ADDRESS

M. T. Hillon & Sons Barnesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Furn. laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Con-vulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury taken and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 4 1903

BUREAU

MARGIN RESERVED FOR BINDING - THIS IS A PERMANENT RECORD

V. S. No. 1.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery
Village or City Poolesville (No. 129) St.; Ward)
2 FULL NAME Leoric Williams Pook
Registration Dist. No. 212
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE ☐ MARRIED ☒ WIDOWED ☐ OR DIVORCED ☐
(Write the word)

6 DATE OF BIRTH 5 - 13 - 1894
(Month) (Day) (Year)

7 AGE 35 yrs. 9 mos. 20 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Poolesville

PARENTS
10 NAME OF FATHER John Henry Williams
11 BIRTHPLACE OF FATHER (State or country) Poolesville Md
12 MAIDEN NAME OF MOTHER Sallie White
13 BIRTHPLACE OF MOTHER (State or country) Poolesville

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. M. Williams
(Address) Poolesville Md

15 Filed Mar 14 1930 E. W. White
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 13 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 12 1930 to Mar 13 1930, that I last saw her alive on Mar 13 1930, and that death occurred on the date stated above, at 4:20 pm.

The CAUSE OF DEATH * was as follows:
Subarachnoid hemorrhage
unknown

Contributory (Duration) yrs. mos. ds. Cerebral Hemorrhage
Secondary 11 hrs
(Duration) 0 yrs. 0 mos. 0 ds.

(Signed) E. W. White M. D.
Mar 14 1930 (Address) Poolesville

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Farmer or usual residence

19 PLACE OF BURIAL OR REMOVAL Bealsville DATE OF BURIAL March 15, 1930

20 UNDERTAKER Hilton and Hall ADDRESS Poolesville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

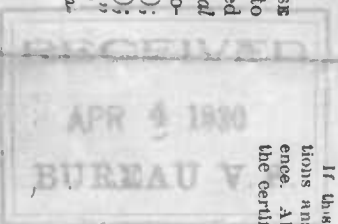
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis,*

peritonaeum, etc., Carcinoma, Sarcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St.:

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,

MARRIED, Widower

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than

1 day hrs.

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1920

Registral

13929

(146)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1920

to

1920

that I last saw him alive on

1920

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Cerebral embolism

(Duration)

yrs.

mos.

21 ds.

Contributory
Secondary

(Duration)

yrs.

mos.

5 ds.

(Signed)

Wm. D. Source

M. D.

Mr. 3

(Address)

Dawsonville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Beallsville Md

Mr. 4, 1920

20 UNDERTAKER

ADDRESS

Ruben Pumphrey

Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Lumber—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

DEC 5 1913

BUREAU

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1 PLACE OF DEATH

County Montgomery

04474

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223Village or City Takoma Park No. 912 Carroll Ave. St. _____ Ward) _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Eliza Ann Pound

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word) widowed

6 DATE OF BIRTH

June 26, 1843
(Month) (Day) (Year)

7 AGE

96 yrs. 9 mos. 255 ds. or min. ?
IF LESS than
1 day....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work. none

(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE
(State or country)New York

10 NAME OF FATHER

George Howard

11 BIRTHPLACE OF FATHER

(State or country) Maine

12 MAIDEN NAME OF MOTHER

Ann Tabor

13 BIRTHPLACE OF MOTHER

(State or country) Maine

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. G. Keefe(Address) Cherry Chase Md

15

Filed April 20 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 20, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Jan. 10, 1930, to Apr. 20, 1930.
that I last saw him alive on Apr. 13, 1930.and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH was as follows:

arterio-sclerosisIndefinite (Duration) yrs. mos. da.Contributory
SecondarymyocarditisIndefinite (Duration) yrs. mos. da.(Signed) D. S. Little M. D.Apr. 20, 1930. (Address) 6911 5th Ave. N.W.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash. D.C.Apr. 20-30

20 UNDERTAKER

John Lee's Sons

ADDRESS

332-Pa. Ave
Wm.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary firemen*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anæmia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," " hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MAY 3 1920
BUREAU

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated. EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery10554 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223Village or City Takoma Park (No. Washington Sanitarium Hospital St. 214 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Mr. W. Lucien Powell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, Married, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH December 13 1846
(Month) (Day) (Year)

7 AGE 83 yrs. 9 mos. 14 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Artist

(b) General nature of industry, business, or establishment in which employed or (employer) Painting Pictures

9 BIRTHPLACE
(State or country)Virginia

10 NAME OF FATHER

John Lucien Powell11 BIRTHPLACE OF FATHER
(State or country)Virginia

12 MAIDEN NAME OF MOTHER

Maria Louise Grady13 BIRTHPLACE OF MOTHER
(State or country)Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records(Address) Takoma Park, Md.15 Filed Sept 27 1930 W. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

September 27 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept 1 1930 to 9/27 1930that I last saw him alive on 9/27 1930
and that death occurred on the date stated above, at 8:25 a.m.

The CAUSE OF DEATH * was as follows:

Broncho pneumoniaContributory
Secondary

Diabetes mellitus, Ch. Degenerative
Myocarditis (Duration) 3 yrs. mos. ds.

(Signed) W. E. Rogers M. D.
Sept 27 1930 (Address) Wash. San. Takoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 26 ds. In the State 0 yrs. 0 mos. 26 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1923 G St. Washington D.C.

19 PLACE OF BURIAL OR REMOVAL

Wash. D.C.

DATE OF BURIAL

Sept 30 1930

20 UNDERTAKER

Wash. D.C. Wash. D.C.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

REC'D
OCT 6 1930
BUREAU V. S.

15173

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 2-31 PLACE OF DEATH
County MontVillage or City Rockville (No. _____)

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME George H. Prather

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH Aug 23, 1894
(Month) (Day) (Year)7 AGE 36 yrs. 3 mos. 19 ds. IF LESS than 1 day ____ hrs. or ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Ind10 NAME OF FATHER Henry Prather11 BIRTHPLACE OF FATHER (State or country) Ind12 MAIDEN NAME OF MOTHER Evelyn Wood13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Evelyn Prather(Address) Rockville, Ind15 Filed 12-14-1930 Mrs. H. T. Prather
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 12, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 12-9-1930 to Dec 12, 1930.that I last saw him alive on Dec 12, 1930,

and that death occurred on the date stated above, at _____ M.

The CAUSE OF DEATH * was as follows:

Chronic Myocarditis

3 (Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary none

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) D. E. Hawks M. D.Dec 14, 1930 (Address) Rockville Ind

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rockville Ind 12-15, 1930

20 UNDERTAKER ADDRESS

Geo. Snowden Rockville, Ind

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE IN INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

V. S. No. 1

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 6 1911
BUREAU

MARGIN RESERVED FOR BINDING

WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

mont

08173

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City

No. Beck

(No.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Baby Pratt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

col

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

single

6 DATE OF BIRTH

July 20 - 1930
(Month) (Day) (Year)

7 AGE

- yrs. - mos. - ds. or min.?

If LESS than
1 day... hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

none

9 BIRTHPLACE

(State or country)

Md -

10 NAME OF FATHER

Geo Pratt

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Donahy

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Pratt

(Address)

Rockville Md

15 Filed

July 21

1930

Ch. Barnsley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 20 - 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 20 1930 to July 20 1930, that I last saw her alive on July 20 1930, and that death occurred on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH * was as follows:

Stillbirth -

Contributory
SecondaryAcute toxemia with nephritis
(Duration) yrs. - mos. - ds.

(Signed)

Jes. M. Ellison M. D.

July 21 1930 (Address) Sandy Spring Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. - mos. - ds. In the State yrs. - mos. - ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Rockville Md

DATE OF BURIAL

7-22-30

20 UNDERTAKER

Hennrichs & Pumphrey Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Melas* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 4 1930
BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Montgomery

Village or City Hyathtstown (No. _____)

2 FULL NAME Robert Vernon Price

04475
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 211

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH July - 19 - 1861
(Month) (Day) (Year)

7 AGE 68 yrs. 8 mos. 18 ds. or _____ min.?
If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work retired farmer
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Frederick Co., Md.

10 NAME OF FATHER Thomas H. Price

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Lewis

13 BIRTHPLACE OF MOTHER (State or country) Camden Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucy May Price
(Address) Hyathtstown, Md.

15 Filed April 8 1930 Wm. E. Lewis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April - 6 - 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct - 31 - 1929 to April 6 - 1930, that I last saw him alive on April - 6 - 1930, and that death occurred on the date stated above, at 3:45 p. m.

The CAUSE OF DEATH was as follows:
Cerebral Hemorrhage

(Duration) 4 yrs. 2 mos. 2 1/2 ds.
Contributory Chorea
Secondary Chronic interstitial nephritis
(Duration) 5 yrs. 5 mos. 4 ds.
(Signed) J. C. Miller M. D.
April - 6 - 1930 (Address) Hyathtstown, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hyathtstown
20 UNDERTAKER W. O. Burdette & Sons Hyathtstown
ADDRESS Hyathtstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

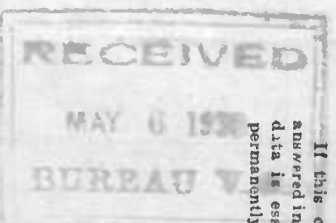
(Approved by U. S. Census and American Public
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Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word, or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Greenery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masks*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

05713

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

Village or City Rockville (No. 129)

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Amrose Proctor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH November 1869
(Month) (Day) (Year)

7 AGE 61 yrs. _____ mos. _____ ds. If LESS than 1 day _____ hrs. or _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Clothes
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Campbell

13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maggie Proctor
(Address) Rockville, Md

15 Filed 5/9 1930 Mrs. W. J. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH _____, 1930
(Month) May (Day) 14 (Year) 1930

17 I HEREBY CERTIFY, That I attended the deceased from May 14 1930 to May 16 1930.

that I last saw him alive on May 14 1930.

and that death occurred on the date stated above, at 8:30 P. m.
The CAUSE OF DEATH * was as follows:

Chronic Myocarditis

(Duration) 5 yrs. _____ mos. _____ ds.

Contributory Ch. Nephritis
Secondary Unknown

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) O. S. Hight M. D.
May 20 1930 (Address) Rockville, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville, Md DATE OF BURIAL 5/19 1930

20 UNDERTAKER Geo. R. Snowden ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Drepsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 9 1870

BUR

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Montgomery*Village or City *Mr. Cedar Grove* (No. _____)

2 FULL NAME

John Purdum

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

*W.*5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)*Single*

6 DATE OF BIRTH

Oct. 5, 1866
(Month) (Day) (Year)

7 AGE

64 yrs. 0 mos. 2 ds. or *min.?*
IF LESS than
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

Retired Farmer

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Rufus Purdum

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Watkins

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Rufus Purdum

(Address)

R.D. Germantown, Md.

15

Filed *Oct. 9, 1930* *Della W. Beall*
Deputy Registrar12564 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *211*

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 7, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Oct. 7, 1930 to *Oct. 7, 1930*
that I last saw him alive on *Oct. 7, 1930*and that death occurred on the date stated above, at *645* m.

The CAUSE OF DEATH * was as follows:

Traumatism - Fractured Skull due to having been struck accidentally by an automobile.
(Duration) *a few seconds.* yrs. mos. ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

George M. Boyer

M. D.

Oct. 9, 1930(Address) *Damascus, Md.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Baptist Church, Cedar Grove, Md.**Oct. 9, 1930*

20 UNDERTAKER

ADDRESS

J. B. Beall, Inc. Damascus, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary) or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data are essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 5 1930

BUREAU

WRITE AGAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed

Jan. 22 1930

J. E. W. W. Deal
RegistrarSTATE OF MARYLAND
CERTIFICATE OF DEATH

0585

Registration Dist. No.

214

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

May 15 1929 to Jan 22 1930

that I last saw him alive on Jan 21 1930

and that death occurred on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH * was as follows:

Contributory
Secondary

(Signed) M. D.

Jan 22 1930 (Address) Silver Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 8 mos. 7 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash D.C.

Fri Jan 24 1930

20 UNDERTAKER

ADDRESS

W. W. Deal Co. 816-10 St. NE

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 7 1930
BUREAU V. S.

WRITE PREVIOUSLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Takoma Park (No. Wash. San & Hosp. St. #302 Ward)

2 FULL NAME Dr. John B. Quinn

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH August 23, 1868
(Month) (Day) (Year)

7 AGE 62 yrs. 3 mos. 1 ds. or min. If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Government Employee
(b) General nature of industry, business, or establishment in which employed or (employer).

9 BIRTHPLACE (State or country) Missouri

10 NAME OF FATHER Mr. Michael Quinn

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Miss Nash

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sanitarium Records

(Address) Takoma Park, Md.

15 Filed Nov 25 1930 H. E. Rogers

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 / 24, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 11 / 21, 1930 to 11 / 24, 1930.

that I last saw him alive on 11 / 24, 1930.

and that death occurred on the date stated above, at 9:15 P. M.

The CAUSE OF DEATH * was as follows:

Pneumonia

(Duration) 3 yrs. 7 mos. 3 ds.

Contributory
Secondary

Ch. Regeneration myocardium

(Signed) A. J. Morsel M. D.

11 / 24, 1930 (Address) Wash. San & Hosp. St. #302

*State the Disease Causing Death, or, if deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 3 mos. 3 ds. In the State 3 yrs. 3 mos. 3 ds.

Where was disease contracted, if not at place of death? Home

Former or usual residence Indiana Head, Ind.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Chas. Glymont, Md. 11 - 28, 1930

20 UNDERTAKER ADDRESS

J. P. Lewis & Sons 332 - Pa. Ave. Wash. D. C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Dealer," et., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer* (retired 6 yrs). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Masks* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rancher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

REC-11
DEC 5 1930
BUREAU V.S.

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1 PLACE OF DEATH

County Montgomery

05714

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213Village or City Rockville (No. Chestnut Lodge Sanitarium Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Mary C. Quinn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Write the word)6 DATE OF BIRTH May 7 1860
(Month) (Day) (Year)7 AGE 70 yrs. 0 mos. 23 ds. or min.? If LESS than 1 day ____ hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Virginia10 NAME OF FATHER Jo Mitchell Conrad11 BIRTHPLACE OF FATHER (State or country) Virginia12 MAIDEN NAME OF MOTHER Sarah Sneed13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed 5-31 1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 30 1930
May (Month) 30 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from May 13 1930 to May 30 1930that I last saw her alive on May 30 1930and that death occurred on the date stated above, at 1:50 P.M.
The CAUSE OF DEATH * was as follows:Chronic Myocarditisunknown (Duration) ____ yrs. ____ mos. ____ ds.Contributory Cerebral Arteriosclerosis
Secondaryunknown (Duration) ____ yrs. ____ mos. ____ ds.(Signed) Dexter M. Bullard M.D.
May 30 1930 (Address) Rockville Md.

*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. 23 ds. In the State ____ yrs. ____ mos. 23 ds.Where was disease contracted, if not at place of death? unknownFormer or usual residence Washington D.C.19 PLACE OF BURIAL OR REMOVAL Hollywood Cemetery
Richmond Va. DATE OF BURIAL June 1, 193020 UNDERTAKER W. R. Humphrey Jr. ADDRESS Rockville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Completed

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

08514

(162)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

Village or City Silver Spring (No. 722 Silver Spring Ave. St. _____ Ward _____) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Elsie Raeburn

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 15, 1930 (Month) (Day) (Year)

7 AGE _____ If LESS than 1 day _____ hrs. _____ yrs. _____ mos. 1 ds. or _____ min.

8 OCCUPATION (a) Trade, profession or particular kind of work None (b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John Francis Raeburn

11 BIRTHPLACE OF FATHER (State or country) District of Columbia

12 MAIDEN NAME OF MOTHER Sadie Elizabeth Van Horn

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John T. Raeburn

(Address) 722 Silver Spring Ave. Silver Spring Md.

15 Filed July 16, 1930 J. E. Wudley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 16, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 15, 1930 to July 16, 1930 that I last saw her alive on July 16, 1930

and that death occurred on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH * was as follows:

Congenital Atelectasis

(Duration) _____ yrs. _____ mos. one ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. H. Nowlett M. D.

July 16, 1930 (Address) 928 Bligo Ave Silver Spring Md.

State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Forest Glen

DATE OF BURIAL

July 17, 1930

20 UNDERTAKER

John J. Raeburn

ADDRESS

Silver Spring Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Plunker, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day Laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

RECEIVED

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . ; (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rentier wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE AGAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg

Village or City Bryds (No. _____) St. _____ Ward _____

2 FULL NAME Anthony Moreland Ray

03117 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 211

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH April 17, 1868
(Month) (Day) (Year)

7 AGE 62 yrs. 9 mos. 27 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Alfred H. Ray

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Allie Getch

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. Maughlin

(Address) Bryds

15 Filed Mar 17 19230 Wm E Lewis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 14, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 7, 1930 to 14, 1930

that I last saw him alive on March 14, 1930

and that death occurred on the date stated above, at 6 P m.

The CAUSE OF DEATH * was as follows:

Thrombosis of Coronary artery (Myocarditis)

(Duration) ____ yrs. ____ mos. 7 ds.

Contributory Secondary Chronic Endocarditis

(Duration) 10 yrs. ____ mos. ____ ds.

(Signed) U. S. Brown M. D.

8/16 1930 (Address) Dawsonville Ga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

13 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rock Creek D.C.

DATE OF BURIAL Mar 17, 1930

20 UNDERTAKER W. R. Humphrey Jr Rockville Md

ADDRESS

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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APR 7 1920

BUREAU

MARGIN RESERVED FOR BINDING
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Montgomery

08174 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

Village or City Bethesda (No. 124 Melrose Ave St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Flora Frances Redfield

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, Married WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH Oct. 23 1864 (Month) (Day) (Year) 7 AGE 66 yrs. 8 mos. 24 ds. or min. If LESS than 1 day hrs. min.

8 OCCUPATION (a) Trade, profession or particular kind of work Housewife (b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ohio

10 NAME OF FATHER Henry Huber

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry J. Redfield

(Address) Bethesda Md.

15 Filed July 18 1930 I Benj. C. Perry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17 1930 (Month) 17 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 1929 to July 11 1930 that I last saw her alive on July 17 1930

and that death occurred on the date stated above, at m. The CAUSE OF DEATH * was as follows:

Mitral Insufficiency (Duration) 1 yrs. mos. ds.

Contributory Secondary (Duration) yrs. mos. ds.

(Signed) Edwin E. Roberts M. D. 7/17 1930 (Address) 3213 Ga a

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Congressional Wash. Dc July 19 1930 20 UNDERTAKER ADDRESS The S. H. Miner Co Wash. Dc

2212 New Arc

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Drugsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Montgomery

01825

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *223*

Village or City

Lakma Park(No. *58**Sycamore av.*

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Margaret Augusta Redhead

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

July 15, 1885
(Month) (Day) (Year)

7 AGE

44 yrs. *76* mos. *17* ds. or *1* day *17* hrs. *17* min. ?
If LESS than 1 day.... hrs. ?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Washington D.C.

10 NAME OF FATHER

*Rudolph Scheitlin*11 BIRTHPLACE OF FATHER
(State or country)*Washington D.C.*

12 MAIDEN NAME OF MOTHER

*Hattie M. Hilton*13 BIRTHPLACE OF MOTHER
(State or country)*Washington D.C.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hattie M. Burnett (mother)

(Address)

58 Sycamore av. Lakma Park

15

Filed

7/2 1930

192

H. E. Rogers

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb. 2, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Jan. 3, 1930, to Feb. 2, 1930.
that I last saw her alive on *Feb. 1, 1930.*and that death occurred on the date stated above, at *9 P.M.*

The CAUSE OF DEATH was as follows:

*Pulmonary Tuberculosis*Contributory
Secondary(Signed) *A. J. Little* M. D.
Feb. 2, 1930 (Address) *6911 8th NW Wash. D.C.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... da. In the State, ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash. D.C. 2/3, 1930

20 UNDERTAKER

ADDRESS

Wm. J. Mallory 622-8th St. W. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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(a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. (are should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatsoever, write *None*.

Statement of Cause of Death—Name, first, the immediate cause, the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhoid cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
MAR 4 1918
BUREAU

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Pakoma Park (No. 18 Sherman Ave.)

2 FULL NAME Waller Edward Reed

10555
(113) STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH July 8, 1930
(Month) (Day) (Year)

7 AGE 3 yrs. 10 mos. 10 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) District of Columbia

10 NAME OF FATHER Walter E. Reed

11 BIRTHPLACE OF FATHER (State or country) Ill.

12 MAIDEN NAME OF MOTHER W. P.

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Frank Burne
(Address) 18 Sherman Ave.

15 Filed Sept 28 1930 Lo. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 28, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept. 27, 1930 to Sept. 28, 1930, that I last saw him alive on Sept. 27, 1930,

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH * was as follows:

Acute gastro-enteric intoxication & infection

(Duration) yrs. mos. ds. 2 ds.
Contributory Chr. Enteritis
Secondary

(Duration) yrs. mos. ds. 1 mos. 1 ds.
(Signed) Lo. E. Rogers M. D.
9/28 1930 (Address) Pakoma Park Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wash D.C. DATE OF BURIAL 9-28, 1930

20 UNDERTAKER W. W. Deal Co ADDRESS 814-H St N.E.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rencher wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

1930

BUREAU

MARGIN RESERVED FOR BINDING

WRITE INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Rockville (No. _____)2 FULL NAME Reed15174 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Unknown</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>
-------------------------	---------------------------------	--

6 DATE OF BIRTH Dec. 13, 1930
(Month) (Day) (Year)

7 AGE Stillborn If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Rockville, Md.

10 NAME OF FATHER Philip Reed
11 BIRTHPLACE OF FATHER (State or country) Montg Co., Md.
12 MAIDEN NAME OF MOTHER Zelda M. Fisher
13 BIRTHPLACE OF MOTHER (State or Country) Rockville, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Philip Reed
(Address) Rockville, Md.

15 Filed 12-13-1930 Wm H. J. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 13, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec. 13, 1930 to Dec. 13, 1930.
that I last saw him - alive on Dec. 13, 1930.
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH * was as follows:
Abortion at 2 months

Contributory (Duration) ____ yrs. ____ mos. ____ ds.
Secondary Unknown

(Signed) Wm A. Lathrop M. D.
Dec. 13, 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville DATE OF BURIAL 12-13, 1930

20 UNDERTAKER Philip Reed ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugstain, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Renal wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

04476

(90)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Lakoma Park ~~Washington Sanitarium & Hospital~~ (If death occurred in a hospital or institution, give its NAME, instead of street and number.)
2 FULL NAME Mrs. Jennie Rice

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH June 16, 1868
(Month) (Day) (Year)

7 AGE 61 yrs. 10 mos. 20 ds. or min. If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) West Virginia

10 NAME OF FATHER George Perrine

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Rebecca Jane Norris

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington Sanitarium Records
(Address) Lakoma Park, MD.

15 Filed Apr 7 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 6, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 31, 1930 to April 6, 1930, that I last saw her alive on April 6, 1930, and that death occurred on the date stated above, at 11 p. m. The CAUSE OF DEATH * was as follows:

Pneumonia

Contributory (Duration) ____ yrs. ____ mos. 15 ds.
Secondary Chronic myocarditis

(Signed) C. J. Larsen M. D.
Apr. 6, 1930 (Address) 1309 P. Lane N.W., Wash. D.C.

*State the Cause of Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. 6 ds. In the State ____ yrs. ____ mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 226 Murray Ave., Alexandria, Va.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Alexandria Va April 9, 1930

20 UNDERTAKER ADDRESS
F. Gasch's Son Madisonburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sorecoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmaturia," "Hæmaturia," "Old Age," "Shock," "Insanition," "Marasmus," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 9 1930

BUREAU

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

044777

(37-a)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213Village or City Darnestown (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Josephine M. Rice

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH July 27, 1927
(Month) (Day) (Year)7 AGE 2 yrs. 9 mos. 3 ds. If LESS than 1 day ____ hrs. or ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Montg.-Les md10 NAME OF FATHER Kelley Rice11 BIRTHPLACE OF FATHER (State or country) Montg.-Les Maryland12 MAIDEN NAME OF MOTHER Bessie Wolfe13 BIRTHPLACE OF MOTHER (State or Country) Ghus

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Kelley Rice(Address) Rt 1 Germantown Md15 Filed 4/30 1930 Upstn D. Bourne Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 30, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 11, 1930 to April 29, 1930
that I last saw her alive on April 29, 1930and that death occurred on the date stated above, at 10:24 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Malnutrition
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Upstn D. Bourne M. D.4/30 1930 (Address) Darnestown Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Darnestown DATE OF BURIAL May 2, 1930

20 UNDERTAKER

Ruben Pumphrey ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Tænia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Burtonsville (No. 1)2 FULL NAME John H. Rich05715 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 2-17

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH Aug 19th 1876
(Month) (Day) (Year)7 AGE 53 yrs. 9 mos. 10 ds. or LESS than 1 day _____ hrs. or _____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Md.10 NAME OF FATHER John Rich11 BIRTHPLACE OF FATHER (State or country) Pa.12 MAIDEN NAME OF MOTHER Behndy Croisdale13 BIRTHPLACE OF MOTHER (State or Country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. John H. Rich(Address) Burtonsville, Md.15 Filed 5-29, 1930 C. S. Barnsley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 5/29/, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 1/4/ 1930 to 5/29/ 1930, that I last saw him alive on 5/29/, 1930.

and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH * was as follows:

Brucellae Senn probably
non-malignant sw. 30.Contributory Secondary 1 term phlegia
(Duration) yrs. 6 mos. ds.(Signed) J. M. B. M. D.
5/31/ 1930 (Address) Sandy Sp.

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. _____ mos. _____ ds. In the State yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Burtonsville, Md. DATE OF BURIAL June 1, 193020 UNDERTAKER Lloyd Kaiser ADDRESS Laurel, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

for issued.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Polomac (No. _____)

2 FULL NAME Leonard Windfield Ricketts

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH August 27, 1929
(Month) (Day) (Year)

7 AGE 19 yrs. 26 mos. 26 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm. Thomas Ricketts

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Virginia Shaw

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. Thomas Ricketts
(Address) Polomac, Md.

15 Filed 6/17 19230 Wm. H. T. Riet
Registrar

06849

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 113

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 14, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 14, 1930 to June 16, 1930

that I last saw him alive on June 14, 1930

and that death occurred on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH * was as follows:

Dysentery

(Duration) ____ yrs. ____ mos. 6 ds.
Contributory Secondary None

(Signed) C. E. Hawks M. D.
192____ (Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Polomac Chapel DATE OF BURIAL June 17, 1930

20 UNDERTAKER W. R. Humphrey Jr. ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUL 7 1930
BUREAU

MARGIN RESERVED FOR BINDING
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

01828

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217Village or City Norbeck (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME, its street and number.)

2 FULL NAME Fred. D. Ricks

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) mar6 DATE OF BIRTH Feb 28th, 1882
(Month) (Day) (Year)7 AGE 48 yrs. 11 mos. 21 ds. or min. If LESS than 1 day ____ hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Ind10 NAME OF FATHER Munroe Ricks11 BIRTHPLACE OF FATHER (State or country) alabama12 MAIDEN NAME OF MOTHER Amanda Dorsey13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sadie Ricks
(Address) Norbeck Mt15 Filed Feb 24, 1928 C. S. Barnesley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 21st, 1928
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept - 20 1927 to Feb 21st 1928, that I last saw him alive on Feb 21st 1928, and that death occurred on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH * was as follows:

Carcinoma of Stomach(Duration) ____ yrs. ____ mos. ____ ds.
Contributory cachectia
Secondary(Signed) C. C. Sumblson M. D.
Feb 24th 1928 (Address) Sandy Spring

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL W. Pleasant (Norbeck) DATE OF BURIAL Feb 24, 192820 UNDERTAKER Geo Snowden ADDRESS Rockville Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
MAR 4 1930
BUREAU OF

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1 PLACE OF DEATH

County

Village or City

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF DEATH

6 DATE OF BIRTH

7 AGE

IF LESS than

1 day hrs.

1 day hrs.

1 day hrs.

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed 3/31

1930

Mrs. V. T. Pratt

Registrar

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

03118

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2/3

Village or City

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF DEATH

6 DATE OF BIRTH

7 AGE

IF LESS than

1 day hrs.

1 day hrs.

1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed 3/31

1930

Mrs. V. T. Pratt

Registrar

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.); "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 7 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Mont

Village or City

Olney

(No.)

Mont Co Gen Hosp

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

217

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Wm E. Ridgely

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

sing

6 DATE OF BIRTH

Apr 10th 1930

(Month)

(Day)

(Year)

7 AGE

— yrs. 7 mos. 24 ds. or min.?

If LESS than
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

none

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Ottoway Ridgely

11 BIRTHPLACE OF FATHER

(State or country)

USA

12 MAIDEN NAME OF MOTHER

Hazel Ridgely

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hazel Ridgely

(Address)

Ellicott City, Md

15 Filed

Dec 4, 1930 C. B. Barnesley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 4th 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY That I attended the deceased from Nov 29 - 1930 to Dec 4th 1930.that I last saw him alive on Dec 4th 1930.

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH * was as follows:

Obstructive Cholangitis

(Duration) — yrs. 4 mos. — ds.

Contributory
Secondary

Broncho Pneumonia

(Duration) — yrs. — mos. 6 ds.

(Signed) E. B. Summers M. D.

Dec 4th 1930 (Address) Sandy Springs

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. 6 ds. In the State — yrs. — mos. — ds. life

Where was disease contracted, if not at place of death? Ellicott City, Md

Former or usual residence. No Dayton Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Jennings chapel

Dec 6, 1930

20 UNDERTAKER

ADDRESS

W. P. Pumphrey, Jr

Rockville Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

per issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Scrub, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Enteritis* (avoid use of "Group 1"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Heavily wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 3 1931

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Rockville (No. _____)

2 FULL NAME Mrs. Margaret Catherine Riggs

08175

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH Oct. 2, 1876
(Month) (Day) (Year)

7 AGE 66 yrs. 8 mos. 13 ds. or min. If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Edwin Graham

11 BIRTHPLACE OF FATHER (State or country) Mass.

12 MAIDEN NAME OF MOTHER Alice Lenz

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Helen Bean
(Address) Rockville Md

15 Filed 7-17 1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 15, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended the deceased from Nov. 27, 1929 to July 15, 1930
that I last saw him alive on July 15, 1930

and that death occurred on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH * was as follows:

Coronary thrombosis
with angina pectoris

(Duration) _____ yrs. 2 mos. _____ ds.
Contributory Hypertension - Arteriosclerosis
Secondary

(Signed) W. M. A. Lintner M. D.
July 15, 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville Union Cem DATE OF BURIAL July 17, 1930

20 UNDERTAKER W. R. Humphrey Jr. ADDRESS Rockville, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N B--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Laytonsville (No. 101)

2 FULL NAME Shadrach Riggs

01826

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 218

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE col. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Oct. 10, 1859
(Month) (Day) (Year)

7 AGE 69 yrs. 4 mos. 1 wk. 4 ds. or min.?
If LESS than 1 day. hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed or (employer) Same

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Shadrach Riggs

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca Snowden

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Riggs

(Address) Laytonsville

15 Filed Feb 17 1930 Rebecca Dan Johnson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 2-17-1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 2-10-1930 to 2-17-1930

that I last saw him alive on 2-16-1930

and that death occurred on the date stated above, at 7:15 p.m.

The CAUSE OF DEATH * was as follows:
Myocarditis, Complicating
inflammatory rheumatism,
plus pneumonia

Contributory inflammatory rheumatism (Duration) 2 yrs. 2 mos. 2 ds.
Secondary plus pneumonia

(Signed) W. E. Miller M. D.
2-18-1930 (Address) Gaithersburg, Md.

*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 70 yrs. 0 mos. 0 ds. In the 70 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence. Same

19 PLACE OF BURIAL OR REMOVAL Brook Grove DATE OF BURIAL Feb 20, 1930

20 UNDERTAKER Ray H. Barker ADDRESS Laytonsville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement, never return 'Laborer,' 'Foreman,' 'Manager,' 'Dealer,' etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A 1bhe data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
MAR 7 1904
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			01827		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <i>Montg.</i>			(31)		Registration Dist. No. <i>218</i>	
Village or City <i>Farmers</i> (No. _____)			St.: _____		Ward: _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2 FULL NAME <i>W. Lloyd Riley</i>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <i>M.</i>	4 COLOR OR RACE <i>W.</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Single</i> (Write the word)				
6 DATE OF BIRTH <i>July 20, 1899</i> (Month) (Day) (Year)						
7 AGE <i>30 yrs. 6 mos. 26 ds.</i> If LESS than 1 day ____ hrs. or ____ min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <i>Merchant</i> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <i>MD.</i>						
10 NAME OF FATHER <i>Wm E. Riley</i>						
11 BIRTHPLACE OF FATHER <i>Va.</i> (State or country)						
12 MAIDEN NAME OF MOTHER <i>Annie M. Reed</i>						
13 BIRTHPLACE OF MOTHER <i>Va.</i> (State or Country)						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Mrs. Annie M. Reed</i> (Address) <i>Farmers, Md.</i>						
15 Filed <i>Feb 18 1930</i> <i>Paula Dore Etchison</i> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <i>Feb 16, 1930</i> (Month) (Day) (Year)						
17 HEREBY CERTIFY, That I attended the deceased from <i>18 Feb. 1930</i> to <i>16 Feb. 1930</i> that I last saw him alive on <i>16 Feb. 1930</i> and that death occurred on the date stated above, at <i>10 P.</i> m. The CAUSE OF DEATH * was as follows: <i>Pulmonary T.B.</i> (Duration) <i>6</i> yrs. ____ mos. ____ ds.						
Contributory Secondary (Signed) <i>Stanley W. Barber</i> M. D. <i>18 Feb. 1930</i> (Address) <i>Farmers, Md.</i>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <i>30 yrs. 6 mos. 26 ds.</i> In the State <i>Same</i> yrs. ____ mos. ____ ds. Where was disease contracted, <i>Same</i> not at place of death? <i>Same</i> Former or <i>Same</i> residence.						
19 PLACE OF BURIAL OR REMOVAL <i>Farmers, Md.</i> DATE OF BURIAL <i>28 Feb. 1930</i>						
20 UNDERTAKER <i>E.C. Garner</i> <i>Farmers, Md.</i>						

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Lohorer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 7 1930

BUREAU

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Olney Mont Co</u>			Registration Dist. No. <u>217</u>	
Village or City <u>Olney - Mont Co Gen Hosp</u> (No. <u>128-C</u>)			St. _____	Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Foster Ritchie (Ritskey)</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Coloured</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Mar</u> (Write the word)		
6 DATE OF BIRTH <u>Mar 21 - 1885</u> (Month) (Day) (Year)				
7 AGE <u>45</u> yrs. <u>2</u> mos. <u>12</u> ds. or min. If LESS than 1 day hrs.				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>millress maker</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>Pullman Co -</u>				
9 BIRTHPLACE (State or country) <u>S. C.</u>				
PARENTS	10 NAME OF FATHER <u>unknown</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>unknown</u>			
	12 MAIDEN NAME OF MOTHER <u>unknown</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>unknown</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Jesse Ritskey</u> (Address) <u>1714 10th St N.W. Wash D.C.</u>				
15 Filed <u>June 3 1930</u> <u>Mrs. C. S. Barnley</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>June 3, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>May 30 1930</u> to <u>June 3rd 1930</u> that I last saw him alive on <u>June 2nd 1930</u> and that death occurred on the date stated above, at <u>7:45 PM</u> The CAUSE OF DEATH * was as follows: <u>Fracture of Skull</u> <u>Auto accident</u> (Duration) _____ yrs. _____ mos. <u>4</u> ds.				
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>C. C. Simbleton</u> M. D. <u>June 4 1930</u> (Address) <u>Sandy Spring Md</u> *State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>5</u> yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. <u>4</u> ds. Where was disease contracted, if not at place of death? <u>Rockville Md</u> Former or usual residence <u>438 N. N. Ave Wash D.C.</u>				
19 PLACE OF BURIAL OR REMOVAL <u>Lincoln Mem. Cem</u>				DATE OF BURIAL <u>June 4th 1930</u>
20 UNDERTAKER <u>CE Murray Son</u>				ADDRESS <u>2105 12th St Wash D.C.</u>

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

per issued.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUL 3 1930
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

04478

(129)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217Village or City Elmer (No. _____)

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alexander Rottett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Sept. 19 / 1854
(Month) (Day) (Year)

7 AGE 73 yrs. 5 mos. 25 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) MD

10 NAME OF FATHER Edwards Rottett

11 BIRTHPLACE OF FATHER (State or country) MD

12 MAIDEN NAME OF MOTHER Sabrina S. Dingham

13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sonia C. Rottett(Address) Rockville Rd # 3

15 Filed April 7 1930 at S. Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4 / 5 / 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 4/3/1930 to 4/5/1930, that I last saw him alive on 4/5/1930

and that death occurred on the date stated above, at 1300 m. The CAUSE OF DEATH * was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. 3 mos. 3 ds.Contributory
SecondaryUremia(Duration) 2 yrs. 2 mos. 2 ds.(Signed) J. J. B. B. M. D.4/5/1930 (Address) Sandy Sp.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transfers or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockville 4, 7, 1930

20 UNDERTAKER

ADDRESS

Warner E. Humphrey Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

her issued.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

09393

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

Village or City Dickerson (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Winslow Merle Roberts

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH May 15th 1919
(Month) (Day) (Year)

7 AGE 11 yrs. 3 mos. 4 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Joseph E. Roberts

11 BIRTHPLACE OF FATHER Md.
(State or country)

12 MAIDEN NAME OF MOTHER Carolyn F. Peters

13 BIRTHPLACE OF MOTHER Md
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carolyn F. Roberts
(Address) Dickerson Md

15 Filed Aug 19 1930 Mo. C. C. Hillon
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 19th 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 9th 1930 to Aug 19th 1930, that I last saw him alive on Aug 16th 1930,

and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH * was as follows:

Chronic myocarditis

Contributory Secondary _____
(Duration) 1 yrs. 2 mos. ____ ds.

(Signed) J. E. Roberts M. D.
Aug 19th 1930 (Address) Dickerson

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Mt. M. E. Church Cemetery DATE OF BURIAL Aug 21st 1930

20 UNDERTAKER W. T. Hillon ADDRESS Barneville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (c) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds., Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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SEP 9 1917
BUREAU

N. S.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

09394

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

Village or City

Cherry Chase

(No.)

201 East 2nd

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Marion M. Robinson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

6 DATE OF BIRTH

Oct 26, 1860

(Month)

(Day)

(Year)

7 AGE

70

69

15

27

ds.

or

min.

If LESS than

1 day....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work.

(b) General nature of industry business, or establishment in which employed or (employer)

House Wife

9 BIRTHPLACE

(State or country)

Texas

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

Texas

12 MAIDEN NAME OF MOTHER

Rebecca Allen

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Addie Bush

(Address)

201 - East 2nd Street

15

Filed

8-23

1930

Thomas K. Conrad

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug 23,

(Month)

(Day)

1930 (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

On Aug 18,

1930,

to

1930

that I last saw him alive on

Aug 18,

1930

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH was as follows:

Chronic Myocarditis

Contributory

Secondary

Cholera

(Duration)

6

da.

(Signed)

James H. McGray

M. D.

at

23

1930

(Address)

2009 Baltimore Rd

W. D. 156

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place

of death

yrs.

mos.

da.

In the

State,

yrs.

mos.

Where was disease contracted, if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash D. C.

Aug 25, 1930

20 UNDERTAKER

W. W. Chambers

ADDRESS

1400 - Chapin St N

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name organ); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Transition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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SEP 3 1930
BUREAU V S

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

1. B.--Every item of information should be carefully supplied. ACE should be filled EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

03119

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from 1930. to Nov 29, 1930.

that I last saw him alive on Jan 1930. and that death occurred on the date stated above, at The CAUSE OF DEATH * was as follows:

Contributory Secondary

(Signed) E. W. White M. D. Mar 36 1930 (Address) Poolsville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

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(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *shop pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 4 1900
BUREAU

PLACE OF DEATH

County Montgomery

04479

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Bethesda, Md. (No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Anna Mae Rodgers,

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single6 DATE OF BIRTH May 19th, 1902
(Month) (Day) (Year)7 AGE 28 yrs. 0 mos. 27 ds. or min. (If LESS than 1 day hrs.)

OCCUPATION

(a) Trade, profession or particular kind of work Clerk,
(b) General nature of industry business, or establishment in which employed or (employer) Government9 BIRTHPLACE (State or country) Maryland.10 NAME OF FATHER John E. Rodgers11 BIRTHPLACE OF FATHER (State or country) Maryland.12 MAIDEN NAME OF MOTHER Katherine Lochte13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sgt. LeRoy Rodgers,(Address) Bethesda, Maryland.15 Filed Apr. 17 1930 Registrar [Signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 16th, 1930
(Month) 16 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from December 1928 to Apr. 16th, 1930that I last saw her alive on Apr. 16, 1930and that death occurred on the date stated above, at 8 A. m.

The CAUSE OF DEATH * was as follows:

Pulmonary tuberculosis(Duration) 2 yrs. mos. ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) [Signature] M. D.Apr. 16, 1930 (Address) Bethesda, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

St. Mary's Cemetery, Rockville, Md. DATE OF BURIAL Apr. 18, 1930

20 UNDERTAKER

Warner E. Pumphrey ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data are essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT 16 1916

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Montgomery

STATE OF MARYLAND
CERTIFICATE OF DEATH

0586

Registration Dist. No. 214

Village or City

Silver Spring

St.

Ward)

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

ROWLAND, BROOKE LEE

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

Jan 11/30, 1920
(Month) (Day) (Year)

7 AGE

2 yrs. 2 mos. 2 ds. or min. ?

8 OCCUPATION

(a) Trade, profession or particular kind of work.
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Silver Spring, Md

10 NAME OF FATHER

Rowland, Richard David

11 BIRTHPLACE OF FATHER

(State or country)

Hagerstown, Md

12 MAIDEN NAME OF MOTHER

Schmidt, Marie

13 BIRTHPLACE OF MOTHER

(State or country)

Williamsport, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

R. W. Rowland

(Address)

Silver Spring, Md

15

Filed

Jan 13 1920

J. S. Winderup

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 13, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Jan 11, 1920, to Jan 13, 1920.
that I last saw him alive on Jan 13, 1920;

and that death occurred on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH was as follows:

Prematurity (2 months)

Contributory
Secondary

(Duration) yrs. mos. 2 ds.

(Duration) yrs. mos. da.

(Signed) E. Mitchell M. D.

Jan 13, 1920. (Address) Silver Spring

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. da. In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hagerstown, Md

1/14, 1920

20 UNDERTAKER

ADDRESS

Father

Silver Spring, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by curative acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 7 1930
BUR

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

15176

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214Village or City Silver Spring (No. 615)St. Mississippi Ward 615 (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Rowland, Richard

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE White5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single6 DATE OF BIRTH Dec. 28, 1930

(Month) (Day) (Year)

7 AGE

If LESS than 1 day 2 hrs. 2 min.?

yrs. mos. ds.

8 OCCUPATION

(a) Trade, profession or particular kind of work —(b) General nature of industry business, or establishment in which employed or (employer) —9 BIRTHPLACE (State or country) Montgomery10 NAME OF FATHER Rowland Richard Dand

PARENTS

11 BIRTHPLACE OF FATHER (State or country) Hagerstown, Md12 MAIDEN NAME OF MOTHER Schmidt, Marie13 BIRTHPLACE OF MOTHER (State or country) Williamsport, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard D Rowland(Address) 615 Miss. Ave.15 Filed Dec. 28, 1930 J. E. Dandridge Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 28, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec. 28, 1930 to Dec. 28, 1930.that I last saw him alive on Dec. 28, 1930.and that death occurred on the date stated above, at 11:15 A.M. The CAUSE OF DEATH * was as follows:Permaternity(Duration) 7 yrs. mos. ds.Contributory
Secondary(Duration) — yrs. mos. ds.(Signed) J. E. Dandridge M. D. Dec. 28, 1930 (Address) Silver Spring, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. mos. ds. In the State — yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence —19 PLACE OF BURIAL OR REMOVAL Hagerstown, MdDATE OF BURIAL 29th 19 3020 UNDERTAKER FatherADDRESS Richard D Rowland 615 Miss ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer, retired 6 yrs.* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 5 1931

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Cherry Chase Gardens

2 FULL NAME

*Herbert L. Royce*STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *216*

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)*Widowed*

6 DATE OF BIRTH

Dec 17

(Month)

17

(Day)

1848

(Year)

7 AGE

81

yrs.

7

mos.

27

ds.

If LESS than

1 day _____ hrs.

or _____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Wilmington Del.

10 NAME OF FATHER

Hugh Royce

11 BIRTHPLACE OF FATHER

(State or country)

Del.

12 MAIDEN NAME OF MOTHER

Eva George

13 BIRTHPLACE OF MOTHER

(State or Country)

Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Miss Mabel V. Royce

(Address)

4612 - Hunt Ave. Md.

15

Filed

8/15/30

192

Benj. O. Perry.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*August 14**1930*

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*July**1928*

to

*August 14**1930*

that I last saw him alive on

*August 14**1930*and that death occurred on the date stated above, at *10 AM* m.

The CAUSE OF DEATH * was as follows?

Arteriosclerosis - Cerebral Hemorrhage

(Duration)

yrs.

mos.

ds.

Contributory
Secondary*Hypostatic pneumonia*

(Duration)

yrs.

mos.

ds.

(Signed)

John J. Lynch

M. D.

Aug 14 30

(Address)

3120 7th St. NW, DC.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Washington Del.

DATE OF BURIAL

8/16

19

30

20 UNDERTAKER

J. W. Lee - Sons

ADDRESS

Washington Del.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
SEP 3

MARGIN RESERVED FOR BINDING
WRITE MAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

12878 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

Village or City Wheaton (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William Jacob Royer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH February 25, 1875
(Month) (Day) (Year)

7 AGE 55 yrs. 8 mos. 3 ds. or min. If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Conrad Royer

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lavinia Bell

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rodina F. Royer
(Address) Brookville, Ind.

15 Filed Oct 31 1920 W. H. Dixon
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct - 28, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept - 20 to Oct - 28, 1920
that I last saw him alive on Oct - 28, 1920
and that death occurred on the date stated above, at 11:50 a.m.
The CAUSE OF DEATH was as follows:

Acute lymphoid leukemia

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Pneumonia (hypostatic)
Secondary

(Signed) Chas. L. Smith M. D.

10/30/20 (Address) Parsonsville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. Ind.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lebanonville Cemetery Oct 31, 1920

20 UNDERTAKER ADDRESS
Roy W Barber Lebanonville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds., Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

DEC 6 1930

BUREAU

MARGIN RESERVED FOR BINDING
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County MontgomeryVillage or City Tobacco, Md. (No. _____)2 FULL NAME Maria Rozier05716 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE 6 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)6 DATE OF BIRTH May 4, 1928
(Month) (Day) (Year)7 AGE 2 yrs. 0 mos. 2 ds. or LESS than 1 day ____ hrs. ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Md.10 NAME OF FATHER Albert Rozier11 BIRTHPLACE OF FATHER (State or country) Md.12 MAIDEN NAME OF MOTHER May Thurston13 BIRTHPLACE OF MOTHER (State or Country) Ca

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maria Rozier

(Address) _____

15 Filed May 6 1930 J. E. Widdup Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 6, 1928
(Month) 6 (Day) 19 (Year) 3017 I HEREBY CERTIFY, That I attended the deceased from May 1, 1928 to May 5, 1928
that I last saw her alive on May 5, 1928and that death occurred on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH * was as follows:

Broncho-pneumonia

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Mary S. Lucas M. D.
May 6, 1928 (Address) 1738-15th

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Nash. D.C. DATE OF BURIAL 5/9, 193020 UNDERTAKER W. E. Davis ADDRESS 1432 You

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugstain, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lebor pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Assthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Ethaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

*Montgomery*Village or City *Near Montrose* (No.)

St.: Ward:

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

*(Stillborn) Russman*Registration Dist. No. *2/3*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

unknown

4 COLOR OR RACE

*white*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)*Stillborn*

6 DATE OF BIRTH

November 13, 1930
(Month) (Day) (Year)

7 AGE

Stillborn
yrs. mos. ds. or min.?If LESS than
1 day hrs.
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

Norman Russman

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Syndell V. Gue

13 BIRTHPLACE OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norman Russman

(Address)

Rockville #3

15 Filed

11-18

1930

Mrs. H. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 13, 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

(Stillborn)

that I last saw him alive on 192....

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

*(Stillborn)
(2 months)*Contributory
Secondary

(Duration) yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

G. F. Hartley

M. D.

Nov. 13, 1930 (Address) *Rockville*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Montrose**Nov. 13, 1930*

20 UNDERTAKER

ADDRESS

Norman Russman Rockville #3

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

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Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Insanition," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. 2.

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B. Every item of information should be carefully supplied. ACE should be stated ACTUALLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Rockville (No. Chestnut Lodge Sanitarium Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Dorothy RyanSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)6 DATE OF BIRTH Nov 22, 1909
(Month) (Day) (Year)7 AGE 20 yrs. 10 mos. 12 ds. or min.?
If LESS than 1 day... hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE
(State or country) Minnesota10 NAME OF FATHER Jessie B. Ryan.11 BIRTHPLACE OF FATHER
(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. Dexter M. Bullard.(Address) Rockville Md.15 Filed 10-2 1930 W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 2, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept 18, 1930 to Oct 2, 1930that I last saw her alive on Oct 2, 1930and that death occurred on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH * was as follows:

Dysentery (undetermined origin)
Autopsy refused by relativesStreptococcus dysenteriae (Duration) yrs. mos. 3 ds.Contributory Acute tonsillitis swollen
Secondary(Signed) Dexter M. Bullard M.D.
Oct 2 1930 (Address) Rockville Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death - yrs. - mos. 13 ds. In the State - yrs. - mos. 13 ds.Where was disease contracted, Unknown
if not at place of death?Former or usual residence Washington D.C.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington Oct. 2, 1930

20 UNDERTAKER

S. H. Hines Co

ADDRESS

2901-14th St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite): *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL," *septicæmia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A little care is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 5 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Bethesda (No. ... St. ... Ward)

2 FULL NAME Sister Mary Genevieve Ryan

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, ~~MARRIED,~~ ~~WIDOWED,~~ ~~OR DIVORCED,~~ (Write the word)

6 DATE OF BIRTH Jan 9 - 1894
(Month) (Day) (Year)

7 AGE 36 7 19 If LESS than 1 day....hrs. 1 yr....mos. 1 ds. or....min. ?

8 OCCUPATION
(a) Trade, profession or particular kind of work Sisterhood
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) N.Y. City

10 NAME OF FATHER Daniel Ryan
11 BIRTHPLACE OF FATHER (State or country) England
12 MAIDEN NAME OF MOTHER Jane Carpenter
13 BIRTHPLACE OF MOTHER (State or country) Red Hook N. Y.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sister Ignatia Flennery
(Address) Convent

15 Filed 8/28 1930 Benj. C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 28, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 1 1930, to Aug 28, 1930, that I last saw her alive on Aug 27, 1930, and that death occurred on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 6 mos. ... da.

Contributory Secondary Chronic Exemia

(Signed) James F. O'Donnell M. D.
8/28 1930 (Address) 427 Collier Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal. Bethesda, Md.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ... yrs. ... mos. ... da. In the State, ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or actual residence New York State

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Washington D. C. Aug 28, 1930

20 UNDERTAKER ADDRESS
W. W. Pham Inc. 1400 Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) "Spinner," (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeeper* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired & gra.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reefer's wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
SEP 3 1900
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Wt.

Village or City Silver Spring (No. Maplewood St. Ward)

2 FULL NAME Susan A. Ryan

09397

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH 1849 11 1930
(Month) (Day) (Year)

7 AGE 81 yrs. 1 mos. 14 ds. If LESS than 1 day. hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) High Lea.

10 NAME OF FATHER Murphy

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Lusian Lowe

13 BIRTHPLACE OF MOTHER (State or Country) Ireland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lucan Hawland.

(Address) Silver Spring Md

15 Filed Aug 14 1930 J. E. Doolittle Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 14, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 1, 1930 to Aug 14, 1930

that I last saw him alive on Aug 13, 1930

and that death occurred on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH * was as follows:

Ruptured cerebral vessel

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory Secondary Arteriosclerosis

(Duration) 10 yrs. 6 mos. 0 ds.

(Signed) J. B. Hagan M. D.

192 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 1 ds. In the State DC yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence DC

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Clinton Natl Cemetery 8/15, 1930

20 UNDERTAKER ADDRESS W. K. Talbot 3619-14

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 6

DEPT. OF HEALTH

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery08176 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218Village or City New Laytonville No. 2nd

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Leonard O Sabine

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH May 28, 1907
(Month) (Day) (Year)7 AGE 23 yrs. 1 mos. 12 ds. or min.?
If LESS than 1 day _____ hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work instructor in
(b) General nature of industry, business, or establishment in which employed or (employer) aviation9 BIRTHPLACE (State or country) Ind10 NAME OF FATHER Leslie Sabine11 BIRTHPLACE OF FATHER (State or country) Omaha Nebraska12 MAIDEN NAME OF MOTHER Barbara Blazek13 BIRTHPLACE OF MOTHER (State or Country) Austria

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leslie Sabine(Address) Leathersburg15 Filed July 12, 1930 T. H. Dyeon Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 10, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY That I attended the deceased from the first fall in an airplane 1929, 192____, that I last saw him alive on July 10, 1930, and that death occurred on the date stated above, at abt 6 P.M.

The CAUSE OF DEATH * was as follows:

Cerebral Contusion + Hemorrhage caused by a fall in an airplane. Accidental
(Duration) sudden death ds.Contributory
Secondary(Signed) T. H. Dyeon M. D.
July 12, 1930 (Address) Laytonville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Home Cemetery DATE OF BURIAL July 12, 193020 UNDERTAKER Roy W. Barber ADDRESS Leathersburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architec, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, Tetionaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City near Rockville, Md.

2 FULL NAME Louis E. Badtler

10556
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2/3

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Oct. 10, 1840
(Month) (Day) (Year)

7 AGE 90 yrs. 10 mos. 27 ds. or _____ min.?
(If LESS than 1 day _____ hrs.)

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed or (employer) Shoemaker

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Martha E. Dove

(Address) Rockville, Md. R. F. D.

15 Filed 9-9 1930 Was W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 7, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Aug 27, 1930 to Sept 7, 1930
that I last saw him live on Sept 7, 1930

and that death occurred on the date stated above, at 4 P. m.

The CAUSE OF DEATH * was as follows: Senile arteriosclerosis & myocarditis.

(Duration) 5 yrs. _____ mos. _____ ds.

Contributory Secondary none

(Signed) Wm. A. Luthardt M. D.
Sept 9, 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Union Cemetery DATE OF BURIAL Sept. 9, 1930

UNDERTAKER Warner E. Pumphrey ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data are essential and must be obtained before the certificate is permanently filed.

OCT 4 1900

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

13932

(90)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

Village or City near Rockville

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mary Elizabeth Sadler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

6 DATE OF BIRTH March 29, 1849
(Month) (Day) (Year)

7 AGE 80 yrs. 3 mos. 29 ds. or min.?
If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Francis B. Bagley

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or Country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha E. Dove
(Address) Rockville, Md.

15 Filed 12-1- 1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 29, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from January 1930 to Nov. 29, 1930
that I last saw her alive on Nov. 29, 1930

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH * was as follows:

Arteriosclerosis, Chronic myocarditis, old hemiplegia

(Duration) 6 yrs. _____ mos. _____ ds.

Contributory Secondary none

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Wm. A. Lathrop M. D.
Dec. 1, 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St. Mary's Cem., Rockville DATE OF BURIAL Dec. 2, 1930

20 UNDERTAKER Warner E. Pumphrey, Rockville, Md. ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH		STATE OF MARYLAND	
County <u>Montgomery</u>		CERTIFICATE OF DEATH	
Village or City <u>Cherry Chase</u> (No. <u>5</u> <u>E. Melrose</u> St.; _____ Ward)		Registration Dist. No. <u>216</u>	
2 FULL NAME <u>Edwin R. Pitt Sampson, Jr.</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)	
6 DATE OF BIRTH <u>Aug. 23, 1904</u> (Month) (Day) (Year)			
7 AGE <u>25</u> yrs. <u>9</u> mos. <u>16</u> ds.		If LESS than 1 day, ____ hrs. OR ____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Student</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Calhoun, Va.</u>			
PARENTS			
10 NAME OF FATHER <u>Edwin R. Pitt Sampson, Jr.</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u>			
12 MAIDEN NAME OF MOTHER <u>Marian R. Haley</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Plainfield, N. J.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Edwin R. Pitt Sampson, Jr.</u> (Address) <u>5-E Melrose St.</u>			
15 Filed <u>6-9th</u> , 19 <u>30</u> , <u>Thomas K. Conrad</u> , REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>June 9</u> , 19 <u>30</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>April 9</u> , 19 <u>30</u> to <u>June 9</u> , 19 <u>30</u> that I last saw him alive on <u>June 8</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>2:30 p. m.</u> The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis</u> <u>about</u> (Duration) <u>6</u> yrs. ____ mos. ____ ds. Contributory <u>bronch. asthma</u> , Secondary (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>W. D. Tewksbury</u> , M. D. <u>Jun 9</u> , 19 <u>30</u> (Address) <u>835 Eye St. NW</u> <u>Washington, D. C.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Richmond, Va.</u>		DATE OF BURIAL <u>6/10</u> , 19 <u>30</u>	
20 UNDERTAKER <u>Jos. Garbassone</u>		ADDRESS <u>1604 Va. Ave. N.W.</u> <u>Washington, D. C.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Vent engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Com-fenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Cherry Branch (No. 107) & Bradley St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Rosmi Schidemanthal

05717 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE WH 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) wid.

6 DATE OF BIRTH May 14, 1859
(Month) (Day) (Year)

7 AGE 71 yrs. 0 mos. 2 ds. or LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ohio

10 NAME OF FATHER Edward Smith
11 BIRTHPLACE OF FATHER (State or country) Pa.
12 MAIDEN NAME OF MOTHER Rachel Braubler
13 BIRTHPLACE OF MOTHER (State or country) Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Rachel Marchly

(Address) 107 & Bradley Ch. Ch.

15 Filed 4-16-1930 Thomas K. Conrad
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 16, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 5. 12, 1930 to 5. 16, 1930.

that i last saw h 2 alive on 5. 16, 1930.

and that death occurred on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH * was as follows:
Chronic Myocarditis

Contributory (Duration) 10 yrs. 0 mos. 0 ds.
Secondary Acute Dilatation

(Signed) John Sharp M. D.
192 (Address) 1861 Bryony Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients & Recent Residents)

At place of death yrs. 1 mos. 0 ds. In the State yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Washington D.C. May 16, 1930

20 UNDERTAKER ADDRESS
Martin W. Hyeroglo 1300 Nat NW.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archibed, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Cancer, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death, approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUN 10 1910
SUR

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>		0587 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Russington</u>		Registration Dist. No. <u>214</u>	
2 FULL NAME <u>William Schuer</u>		St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>Sept 15 1886</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>Jan 18 1930</u> (Month) (Day) (Year)	
7 AGE <u>61</u> yrs. <u>4</u> mos. <u>3</u> ds. or min.?		17 I HEREBY CERTIFY, That I attended the deceased from <u>Jan 7 1930</u> to <u>Jan 18 1930</u> , that I last saw him alive on <u>Jan 17 1930</u> , and that death occurred on the date stated above, at <u>9:05 A.M.</u>	
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Druggist</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____		The CAUSE OF DEATH * was as follows: <u>Acute Myocarditis</u>	
9 BIRTHPLACE (State or country) <u>MD</u>		Contributory <u>Varicella disease</u> (Duration) _____ yrs. _____ mos. _____ ds.	
10 NAME OF FATHER <u>Henry Schuer</u>		(Signed) <u>Charles Price</u> M. D. <u>Jan 18 1930</u> (Address) <u>Russington</u>	
11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>		*State the Cause Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.	
12 MAIDEN NAME OF MOTHER <u>Mary Leight</u>		18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.	
13 BIRTHPLACE OF MOTHER (State or Country) <u>MD</u>		Where was disease contracted, if not at place of death? _____ Former or usual residence _____	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Miss Nellie Geiger</u> (Address) <u>Russington</u>			
15 Filed <u>Jan 19 1930</u> with <u>Seems</u> Registrar		19 PLACE OF BURIAL OR REMOVAL <u>Rock Creek</u> DATE OF BURIAL <u>Jan 18 1930</u>	
		20 UNDERTAKER <u>Adams & Dauphin</u> ADDRESS <u>Russington</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 7 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Washington
CITIES CORPORATE LIMITS OF

Village or City Hagerstown (No. 912 Hamilton Blvd. 5 Ward)

2 FULL NAME Frances May Schilling

03492 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 302

(If death occurred in a hospital or institution, give its NAME, instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Oct 23 1891
(Month) (Day) (Year)

7 AGE 58 yrs. 4 mos. 8 ds. or min. 5 if LESS than 1 day hrs. 2

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country) Ind.

10 NAME OF FATHER Benj R Knoble

11 BIRTHPLACE OF FATHER
(State or country) Ind.

12 MAIDEN NAME OF MOTHER Harriett U. Snyder

13 BIRTHPLACE OF MOTHER
(State or country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Schilling

(Address) Hagerstown Ind

15 Filed 4-1- 1930 Blount Hagerstown
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 31 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan. 12 1930 to March 31 1930.

that I last saw him alive on March 31 1930.

and that death occurred on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH * was as follows:

Acute Encephalitis, encephalitis
upon a chronic encephalitis, of several
months standing. Cause undetermined.
Contributory Heart failure
(Duration) yrs. mos. ds. 1
Secondary

(Signed) B. H. Hagerman M. D.
April 1 1930 (Address) Hagerstown, Ind

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Hagerstown, Ind DATE OF BURIAL Apr 3 1930

20 UNDERTAKER H. H. Coxman ADDRESS Hagerstown

Dr. Hagerman

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Commissioner, Architect, Locomotive engineer, Civil engineer, Stationery fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc.; without more precise specification as *Day laborer, Farm laborer, Lumber—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Melas* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or NONVIOLENT, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1930

BUREAU

MARGIN RESERVED FOR BINDING

WRITE MAIN WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

44480

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

Village or City Forest Glen (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Porter Schooley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Aug. 8, 1870
(Month) (Day) (Year)

7 AGE 59 yrs. 8 mos. 1 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Rev. Wm. D. Schooley

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER Julia A. Divine

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Freda A. Schooley
(Address) Forest Glen, Md.

15 Filed April 9, 1930 W. L. Jones
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 8, 1923
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from March 17, 1923 to Apr 8, 1923, that I last saw him alive on Apr 8, 1923

and that death occurred on the date stated above, at 1 P. m.
The CAUSE OF DEATH was as follows:

Depleting, resulting from loss of blood due to the tumor, which was a fact.
(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Stroke of the right side
Secondary Heart disease to the right side
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Apr 9, 1930 (Address) Lawson, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Herndon, Va. DATE OF BURIAL April 10, 1930

20 UNDERTAKER Warner E. Humphrey ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery;*

(a) *Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 9 1930
BUREAU V. B.

WRITING, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Montrose (No. 162) St. — Ward —

06851 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Charles Elwood Scott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH June 29, 1930
(Month) (Day) (Year)

7 AGE — yrs. — mos. — ds. If LESS than 1 day 11 hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Walter Sickles

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Scott

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac Scott

(Address) Rockville, Md.

15 6/30 1930 Mrs. H. T. Prall
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June 29, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1930 to June 29, 1930, that I last saw him alive on June 29, 1930, and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH * was as follows:
Congenital Atelectasis
5 1/2 hours
(Duration) yrs. mos. ds.

Contributory —
Secondary —
(Duration) yrs. mos. ds.

(Signed) Wheeler, J. H. M. D.
June 29, 1930 (Address) Bethesda, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Montrose, Md. 7/1-30

20 UNDERTAKER ADDRESS

Isaac Scott Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Auto-mobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUL 7 1930
BUREAU V. S.

WRITE IN INK, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Forest Glen (No. _____) St. _____ Ward _____

2 FULL NAME

Scola Smith Scott05718 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214

If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>
------------------------	-----------------------------------	---

6 DATE OF BIRTH

Feb. 16, 1930
(Month) (Day) (Year)

7 AGE

3 yrs. 11 mos. 11 ds. or min. ?
If LESS than 1 day....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country) Forest Glen, Md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

Katherine Scott

13 BIRTHPLACE OF MOTHER

(State or country) Forest Glen, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eleanor Scott(Address) Forest Glen, Md

15

Filed May 28, 1930 J. E. Wadley
Duffy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 27, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

May 27, 1930, to May 27, 1930;
that I last saw her alive on May 27, 1930;and that death occurred on the date stated above, at 9:35 P. M.

The CAUSE OF DEATH was as follows:

Enlarged ThyroidContributory
Secondary(Duration) 3 yrs. 11 mos. 11 ds.(Signed) Ammon Baulthead M. D.May 27, 1930 (Address) Silver Spring, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 3 yrs. 11 mos. 11 ds. In the State, 3 yrs. 11 mos. 11 ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London M. D.May 19, 1930

20 UNDERTAKER

ADDRESS

Thos. Frazee723 J. St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Typhoid cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

RECEIVED

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *20 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Cerebral"), "Seizure," etc.), "Dropsy," "Exhaustion," "Great failure," "Hæmorrhage," "Insanity," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SELFAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverberant wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (If commendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is to be read over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING
WRITE ONLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

13933

(47)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 224Village or City Takoma Park (No. 128 Maple Ave., St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Ella E. Seidel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH
July 10, 1885
(Month) (Day) (Year)7 AGE
45 yrs. 4 mos. 3 ds. or min. If LESS than 1 day hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE
(State or country) Md.10 NAME OF FATHER
Louis A. Eilkocher11 BIRTHPLACE OF FATHER
(State or country) Md.12 MAIDEN NAME OF MOTHER
Anna Weinkam13 BIRTHPLACE OF MOTHER
(State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry E. Seidel(Address) 128 Maple Ave.15 Filed Nov 14 1930 H. E. Seidel Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 13, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Aug. 7, 1930 to Nov. 13, 1930
that I last saw her alive on Nov. 12, 1930and that death occurred on the date stated above, at 3:40 a.m.
The CAUSE OF DEATH * was as follows:Carcinoma of left breast.
(Duration) 6 yrs. mos. ds.Contributory Secondary Cardiac decompensation
(Duration) yrs. mos. 3 ds.
(Signed) Hyman Woodberg M. D.
Nov. 13, 1930 (Address) 410 Cedar Street

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Washington, D.C.

DATE OF BURIAL

Nov. 15, 1930

20 UNDERTAKER

The S. H. Hines Co.

ADDRESS

2901-14th St
Wash., D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

DEC 5 1902

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery15177 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

214Village or City Takoma Park

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME William W. Beitz

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH

April 30, 1865
(Month) (Day) (Year)

7 AGE

65 yrs. 7 mos. 2 ds. or min.?

If LESS than 1 day.....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Interior Dec-

(b) General nature of industry business, or establishment in which employed or (employer)

orator

9 BIRTHPLACE

(State or country)

Washington, D.C.

10 NAME OF FATHER

John F. Beitz

11 BIRTHPLACE OF FATHER

(State or country)

Washington, D.C.

12 MAIDEN NAME OF MOTHER

Alice F. Knight

13 BIRTHPLACE OF MOTHER

(State or Country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. P. Rothrop(Address) Washington, D.C.15 Filed Dec. 2nd 1930 J. E. Dudley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec. 2, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Nov. 28 1930 to Dec. 2, 1930, that I last saw him alive on Dec. 1, 1930,and that death occurred on the date stated above, at 4:20 a. m.

The CAUSE OF DEATH * was as follows:

Gangrenous omental
hernia (inguinal) with
peritonitis
(Duration) 2 yrs. 2 mos. 2 ds.Contributory
Secondary(Signed) Chas. J. Little M. D.
Dec. 2, 1930 (Address) 6911 5th St NW

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Olivet Cemetery Dec. 4, 1930

20 UNDERTAKER

ADDRESS

Warner E. Humphrey Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

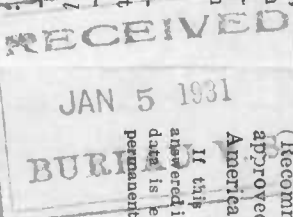
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a question answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Mont -

01829

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City

W. Olney

(No.

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Richard Selby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

col

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

sing.

6 DATE OF BIRTH

July

4th

1930

(Month)

(Day)

(Year)

7 AGE

— yrs. 7 mos. 10 ds.

IF LESS than
1 day hrs.
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Richard Hopkins

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Mildred Selby

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mildred Selby

(Address)

Olney Md.

15

Filed Feb 15

1930

C. S. Barnsley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb

14

1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Feb 6th

1930

to

Feb 14

1930

that I last saw him alive on

Feb 8th

1930

and that death occurred on the date stated above, at 1 P. m.

The CAUSE OF DEATH * was as follows:

Convulsive Seizures

(Duration)

yrs.

mos.

8 ds.

Contributory
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

C. S. Barnsley

M. D.

Feb 14 1930

(Address)

Sandy Spring Md

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Mt Zion

DATE OF BURIAL

Feb 15, 1930

20 UNDERTAKER

Roy Barber

ADDRESS

Fayetteville

for issued

more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 4 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

0588

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 212Village or City Pickersen (No. _____)

St.: _____ Ward: _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Sarah Catherine Selby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)widowed

6 DATE OF BIRTH

July 4, 1857
(Month) (Day) (Year)

7 AGE

72 yrs. 6 mos. 14 ds. or min.?IF LESS than
1 day. hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Housekeeping

(b) General nature of industry business, or establishment in which employed or (employer)

House work.9 BIRTHPLACE
(State or country)Md10 NAME OF
FATHERRobert J. Ricketts11 BIRTHPLACE
OF FATHER
(State or country)Md12 MAIDEN NAME
OF MOTHERSarah C. Dixon.13 BIRTHPLACE
OF MOTHER
(State or country)Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ma Selby Smith

(Address)

Washington D.C.

15

Filed

Jan 20 1930 E. W. White
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 18th, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Jan 12th 1930 to Jan 18th 1930that I last saw him alive on Jan 18th 1930and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH * was as follows:

Influenza(Duration) yrs. mos. 5 da.Contributory
SecondaryBroncho-Pneumonia(Duration) yrs. mos. 4 da.

(Signed)

1/18/1930 (Address) Pickersen M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monacacy Cemetery
Appleville, Md.Jan. 20, 1930

20 UNDERTAKER

ADDRESS

Warner E. Humphrey Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia. Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *23 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *seizures, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 4 1930
BUREAU

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter; Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mecles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mecles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. R.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Montgomery

03121

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216

Village or City

Cherry Chase (No. 15 Grafton)

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Mary Grice Shepherd

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Widow

6 DATE OF BIRTH

December 29, 1842

(Month)

(Day)

(Year)

7 AGE

87 yrs. 2 mos. 10 ds.If LESS than
1 day ____ hrs.
or ____ min.?

8 OCCUPATION

(a) Trade, profession or
particular kind of workHousewife(b) General nature of industry
business, or establishment in
which employed or (employer)Retired9 BIRTHPLACE
(State or country)Washington D.C.10 NAME OF
FATHERWilliam P Young11 BIRTHPLACE
OF FATHER
(State or country)M.C.12 MAIDEN NAME
OF MOTHERSusan Grice13 BIRTHPLACE
OF MOTHER
(State or Country)Phella. Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Mary Shepherd Quintard
15 Grafton St.

15

Filed

Mar. 111930Benj. C. Perry

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 10, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Jan 8, 1932 to March 10, 1930that I last saw her alive on March 9, 1930and that death occurred on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH * was as follows:

Myocarditis - C. HomeContributory
Secondary(Duration) 1 yrs. ____ mos. ____ ds.Arterio Sclerosis(Duration) 18 yrs. ____ mos. ____ ds.(Signed) Eager Snowden M. D.March 10, 1930 (Address) 1712 215 + 200*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington D.C. March 12, 193020 UNDERTAKER Almus R. Spear ADDRESS 1623 Conner

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery;*

(a) *Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not grudgingly employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
APR 5 1930
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Silver Springs

2 FULL NAME Mrs. Florence A. Shinn

01830

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

St.: _____ Ward: _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH

April 1, 1873
(Month) (Day) (Year)

7 AGE

57 yrs. 10 mos. 22 ds. or min.?

IF LESS than
1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

New York

10 NAME OF FATHER

John S. Shinn

11 BIRTHPLACE OF FATHER (State or country)

New York

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (State or country)

11

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Clark Shinn

(Address) 200 Shepard St. Md.

15 Filed Feb 26 1980 F. E. Wadley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Silver Springs Md. 2/23, 1980
Feb, (Month) 23 (Day) 1980 (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

192 to 192

that I last saw him alive on 192

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Patient was dead on arrival
struck by east bound Baltimore & Ohio
train, fractured skull, broken
neck, internal injuries
(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

G. Scully M. D.
Feb 24 1980 (Address) Silver Springs Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Alexandria Va.

Feb. 26 1980

20 UNDERTAKER

ADDRESS

Ed. Murphy

Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 5 1930
BUREAU V. S.

MARGIN RESERVED FOR BINDING
WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County MontgomeryVillage or City Conduit Rd. (No. _____)2 FULL NAME George T. Shoemaker

08177

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216(If death occurred in a hospital or institution, give its NAME instead of street and number.)
St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed6 DATE OF BIRTH Sep. 5, 1852
(Month) (Day) (Year)7 AGE 78 yrs. 10 mos. 1 ds. or _____ min.?
If LESS than 1 day _____ hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Jesse Shoemaker11 BIRTHPLACE OF FATHER (State or country) Penn.12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos Shoemaker(Address) Conduit Rd.15 Filed July 8, 1930 Benj. C. Perry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 6, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 1, 1930 to July 6, 1930
that I last saw him alive on July 3, 1930and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH * was as follows:

Carcinoma of lip and face(Duration) 5 yrs. _____ mos. _____ ds.Contributory Secondary Same(Duration) 5 yrs. _____ mos. _____ ds.(Signed) Wm. Stanton M. D.7/7 1930 (Address) 3323 14th St. N.W.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Potomac, Md. DATE OF BURIAL July 9, 193020 UNDERTAKER Geo M Wise Co ADDRESS Wash. D.C.Wm Stanton

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING
WRITE AINL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Montgomery

03122 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Elroy (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

² FULL NAME Margaret Siskin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 2 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 7, 1911
(Month) (Day) (Year)

7 AGE 18 yrs. 6 mos. 22 ds. or _____ min. If LESS than 1 day _____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Imm.
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ms.

10 NAME OF FATHER Ernest Siskin

11 BIRTHPLACE OF FATHER (State or country) Ill.

12 MAIDEN NAME OF MOTHER Mellie Sumner

13 BIRTHPLACE OF MOTHER (State or country) Ms.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. J. Brown

(Address) Edmondston Ms.

15 Filed Mar 19 1930 A. S. Barnet
Registrar

per isued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 3/19/, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 3/18/ 1930 to 3/19/ 1930.

that I last saw him alive on 3/19/, 1930.

and that death occurred on the date stated above, at 5a m.

The CAUSE OF DEATH was as follows:

Traumatic Pneumonia
Injury on Auto accident at South
Bay Md. (Duration) _____ yrs. _____ mos. 1 ds.

Contributory Shock
Secondary (Duration) _____ yrs. _____ mos. 1 ds.

(Signed) M. B. Siskin M. D.
3/19/ 1930 (Address) Sandy Spring Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hyattsville Md Mar 19 1930

20 UNDERTAKER ADDRESS

J. C. Gachis Son Hyattsville Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Meningitis* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a question answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 4 1930
BUREAU OF VITAL STATISTICS

N. B.--Every item of information should be carefully supplied. ACE should be stated **EXACTLY**, **PHYSICIANS** should state **CAUSE OF DEATH** in plain terms so that it may be properly classified. Exact statement of **OCCUPATION** is very important. See Instructions on back of certificate.

1 PLACE OF DEATH
County Monty Co.

Village or City Germanstown (No.)

2FULL NAME Elsie Simons

13934

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 211

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*
(Write the word)

6 DATE OF BIRTH 1883

(Month) (Day) (Year)

7 AGE _____ If LESS than
_____ day _____ hrs.
45 years yrs. mos. da. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE
(State or country) Maryland.

10 NAME OF FATHER *11* *JP*

11 BIRTHPLACE
OF FATHER
(State or country) *Maryland.*

12 MAIDEN NAME OF MOTHER Cara Burrone

13 BIRTHPLACE
OF MOTHER
(State or Country) *Maryland.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary. Hummel

(Address) Boyd - road

15 Filed Nov 17 1923 *W. H. Lewis* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 14, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from
Nov 7 1930. to Nov. 14, 1930

that I last saw her alive on Nov 14, 1930

and that death occurred on the date stated above, at 6:27 pm.

The CAUSE OF DEATH * was as follows:

Actis myocarditis

(Duration) yrs mos. 10 ds.
Contributory
Secondary *Myocardial heart disease*
late arterial hypertension

(Duration) 10 yrs. 10 mos. 0 ds.
(Signed) Upton K. Brown M. D.
Nov. 14 1923 (Address) Dawsonville, Ga.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Brownstown Ind.	Nov 17, 1930

20 UNDERTAKER	ADDRESS
<i>E. L. Gartner</i>	<i>Gaithersburg</i>

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation, whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 5 1933

BUREAU OF

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Poolesville

2 FULL NAME

Leon Ruell Simms

05719

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Negro

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Sept. 11, 1929

(Month)

(Day)

(Year)

7 AGE

7 yrs. 7 mos. 27 ds. or min.?

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

May 8 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

5 8 1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 26 1930 to May 7 1930.

that I last saw him alive on May 7 1930.

and that death occurred on the date stated above, at 2 A. m.

The CAUSE OF DEATH * was as follows:

Bronch. pneumonia secondary to primary bronch.

(Duration) yrs. 1 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Upton D. Brown M. D.

5/8 1930 (Address) Poolesville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

16 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Martinsburg-Montgomery 5/10 1930

20 UNDERTAKER

ADDRESS

Henry Davis Poolesville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Melas*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Melas* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomerySTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223Village or City Washington San. & Hosp. Takoma Park, Md Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)2 FULL NAME Florence Corinne Simpson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)6 DATE OF BIRTH July 10, 1873
(Month) (Day) (Year)7 AGE 57 yrs. 3 mos. 10 ds. IF LESS than 1 day.....hrs. or.....min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Alexandria, Va.10 NAME OF FATHER Ethelbert Millburn11 BIRTHPLACE OF FATHER (State or country) Alexandria, Va.12 MAIDEN NAME OF MOTHER M. H. Marstella13 BIRTHPLACE OF MOTHER (State or country) Warrenton, Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington San. & Hosp. Records(Address) Takoma Park15 Filed Oct 20 1923 H. H. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 20, 1923
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept. 18, 1920 to October 20, 1923 that I last saw her alive on October 20, 1923 and that death occurred on the date stated above, at 4:13 a.m.The CAUSE OF DEATH * was as follows:
Chr. Degenerative myocarditis - (Decompensation)Contributory Secondary (Duration) yrs. 10 mos. 10 ds.(Signed) Howard L. Smaral M. D.
10/20/1923 (Address) Washington San. & Hosp. Takoma Park, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 1 mos. 2 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence Carroll Ave., Takoma Park19 PLACE OF BURIAL OR REMOVAL Alexandria, Va. DATE OF BURIAL Oct 20, 192320 UNDERTAKER John S. Arnold ADDRESS Alexandria, Va.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Labour pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Imanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia, "Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A thorough date is essential and must be obtained before the certificate is permanently filed.

NOV 4 1930

BUREAU

WRITE IN PLAIN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Lanwood, Forest Glen,

(No.

St.

Ward)

2 FULL NAME

Sims, Mary

6589

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

214

If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

March (unkn) 1873

(Month)

(Day)

(Year)

7 AGE

56 yrs. 10 mos. unkn

If LESS than 1 day....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Montgomery Co, Md

10 NAME OF FATHER

Arthur, Charles

11 BIRTHPLACE OF FATHER

(State or country)

Va. -

12 MAIDEN NAME OF MOTHER

Harriett

13 BIRTHPLACE OF MOTHER

(State or country)

unkn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F. B. Sims

(Address)

Lanwood, Forest Glen, Md

15

Filed

Jan 18 1930

F. B. Dudley

Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan. 16, 1930

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Jan. 8 1930, to Jan. 16, 1930.

that I last saw him alive on Jan. 16, 1930.

and that death occurred on the date stated above, at 1:34 P.M.

The CAUSE OF DEATH was as follows:

Chronic tabular heart disease (arterio-sclerotic)

(Duration) 0 yrs. 2 mos. 15 ds.

Contributory Secondary

Chronic myocarditis

(Duration) 2 yrs. mos. ds.

(Signed)

J. P. Mitchell

M. D.

Jan. 16, 1930. (Address) Lanwood, Forest Glen, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

yrs. mos. da.

In the State

yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Lanwood Md

1/19, 1930

20 UNDERTAKER

ADDRESS

Thos Frazier

Wash D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrovascular fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"; *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.; *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death). 29 ds.; *Bronchopneumonia* (secondary). 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 7 1930
BUREAU V. S.

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomerySTATE OF MARYLAND
CERTIFICATE OF DEATH

0590

Registration Dist. No. 923Village or City Lakewood Park (No. _____)Carrall Ave St.: _____ Ward) _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs. Emma Dale Skedmore

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

☒ MARRIED

6 DATE OF BIRTH

Feb. 22, 1848

(Month)

(Day)

(Year)

7 AGE

81 yrs. 10 mos. 30 ds.

If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Newburg, New York

10 NAME OF FATHER

Samuel Oakley

11 BIRTHPLACE OF FATHER

(State or country)

New York State

12 MAIDEN NAME OF MOTHER

Emily Williams

13 BIRTHPLACE OF MOTHER

(State or Country)

New York State

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sanitarium Records

(Address)

Lakewood Park, Md.

15

Filed

Jan 21 1930

192

H. E. Rogers

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan (Month) 21 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from December 7, 1926, to Jan 21, 19230.that I last saw her alive on Jan 20, 19230.and that death occurred on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH * was as follows:

Myocarditis

(Duration)..... yrs. mos. ds.

Contributory Secondary

Acute Gastritis

(Duration)..... yrs. mos. ds.

(Signed) S. H. Kress M. D.Jan 21, 19230. (Address) Lakewood Park, D.C.

*State the cause of death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 9 mos. 24 ds.In the State 3 yrs. 9 mos. 24 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Newburg, New York

19 PLACE OF BURIAL OR REMOVAL

New DC

DATE OF BURIAL

Jan 23, 19230

20 UNDERTAKER

Thos. W. Hyatt

ADDRESS

1300 N St. N.W.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carboic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
FEB 8 1930
BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Mont.Village or City Gaithersburg (No. _____)2 FULL NAME Annie Betty SkinnerSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218Home for Aged and Orphans, Gaithersburg, Md. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH March 28, 1854
(Month) (Day) (Year)

7 AGE 76 yrs. 9 mos. 1 ds. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Va.10 NAME OF FATHER James Skinner11 BIRTHPLACE OF FATHER (State or country) Va.12 MAIDEN NAME OF MOTHER Betty Beaty13 BIRTHPLACE OF MOTHER (State or country) Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rev. Wilson
(Address) Gaithersburg, Md.15 Filed Dec 30 1930 Rachel Van Pelt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 29, 1930, 192
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 1928 192 to Dec 29, 1930 192that I last saw her alive on Dec 29, 1930, 192and that death occurred on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH * was as follows:

Acute cardiac dilatation(Duration) yrs. mos. 1 ds.Contributory
SecondaryChronic Valvular heart disease(Duration) 5 yrs. mos. ds.(Signed) J. J. Brothman M. D.12-30 1930. (Address) Gaithersburg, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Middleburg Va (Louden Co.) Dec 31, 1930

20 UNDERTAKER ADDRESS

E. C. Gartner Gaithersburg, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

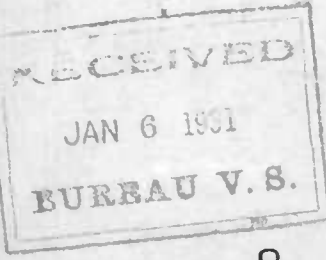
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Fireman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed of given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bacterial pneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonium, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as *PUERPERAL septicaemia, "PUERPERAL peritonitis," etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD. N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH
County Mont

13935

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

Village or City Rockville (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Shan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE wht 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 11 13 1930
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day _____ hrs. _____ yrs. _____ mos. _____ ds. or _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) ind

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (State or country) unknown

12 MAIDEN NAME OF MOTHER Charlotte Shan

13 BIRTHPLACE OF MOTHER (State or Country) va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charlotte Shan
(Address) Rockville

15 Filed 11-13 1930 Mrs. H. T. Prael
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 13 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from _____ 192____ to _____ 192____,

that I last saw him _____ alive on _____ 192____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * as follows:

Still born
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary _____

(Signed) C. E. Hawks M. D.
(Address) Rockville ind
192____ (Duration) _____ yrs. _____ mos. _____ ds.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville DATE OF BURIAL 11-13 1930

20 UNDERTAKER Charlotte Shan ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Senile," etc.), "Dropsy," "Debility" ("Congenital," "Senile," etc.), "Convulsions," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 2 1930

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Lakoma Park md. No. 714 Flower Ave.

2 FULL NAME Infant of Francis W. & Lulu D. Smith

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)
6 DATE OF BIRTH Jan 4, 1930
(Month) (Day) (Year)
7 AGE _____ yrs. _____ mos. 1 ds. or _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland
10 NAME OF FATHER Francis W. Smith
11 BIRTHPLACE OF FATHER (State or country) England
12 MAIDEN NAME OF MOTHER Lulu D. King
13 BIRTHPLACE OF MOTHER (State or Country) D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Francis W. Smith

(Address) 714 Flower Ave

15 Filed Jan 7, 1930 C. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 5, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 4, 1930 to Jan 5, 1930.
that I last saw him alive on Jan 5, 1930
and that death occurred on the date stated above, at 12 P.m.
The CAUSE OF DEATH * was as follows:

Premature birth

Contributory
Secondary

(Duration) 0 yrs. 0 mos. 1 ds.

(Duration) 0 yrs. 0 mos. 1 ds.

(Signed) Wynwood Heiges M. D.

Jan 6, 1930 (Address) 7223 Blair Road

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

md. Cedar Hill Cemetery Jan. 6, 1930

20 UNDERTAKER ADDRESS

The S. H. Hines Co 2901-14 St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 6 1930

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Near Rockville.

(No.)

Rockwell-Horbeck Pike.

Ward)

Registration Dist. No. 213

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Howard Graecelin Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Negro

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

May 2, 1909

(Month)

(Day)

(Year)

7 AGE

21 yrs. 5 mos. 29 ds.

If LESS than

1 day hrs.

or min.?

OCCUPATION

(a) Trade, profession or particular kind of work

Truck driver

(b) General nature of industry business, or establishment in which employed or (employer)

Ice

8 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Grant H. Smith

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Chaisey Harris

13 BIRTHPLACE OF MOTHER

(State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marie Keel

(Address)

727 Kenyon St. N.W. DC

15

Filed

Nov 2"

1920

Mrs. W. T. Pratt

Registrar

13936

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov 2"

1920

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

1920

to

1920

that I last saw h..... alive on....., 1920

and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH * was as follows:

Broken Neck

(Duration)

yrs.

mos.

ds.

Contributory
Secondary

Automobile accident on Rockwell-Horbeck Pike

(Duration)

yrs.

mos.

ds.

(Signed)

M. J. Pratt

M. D.

Nov 2"

1920 (Address)

Rockville, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockville, Md

Nov 4", 1920

20 UNDERTAKER

ADDRESS

Geo. R. Snowden

Rockville, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebro spinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 2 1930

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

12879

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218

Village or City nr. Washington Grove (No. 129)

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Lester Roy Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Unknown
(Month) (Day) (Year)

7 AGE 24 yrs. 2 mos. 4 ds. or 1 day 1 hrs. If LESS than 1 day

8 OCCUPATION
a) Trade, profession or particular kind of work Clerk in store
b) General nature of industry business, or establishment in which employed or (employer)

BIRTHPLACE
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed Oct 19 1930 R. H. Dwyer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 17, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from September 18, 1930, to October 17, 1930, that I last saw him alive on October 16, 1930,

and that death occurred on the date stated above, at 3:40 a.m.

The CAUSE OF DEATH* was as follows:

Sub-acute Interstitial Nephritis

Contributory Secondary Chronic Endocarditis
(Duration) 5 yrs. 5 mos. 5 ds.

(Signed) George M. Boyer M. D.
Oct. 18 1930 (Address) Dallas, Md.

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 5 yrs. 5 mos. 5 ds. In the State 5 yrs. 5 mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Redland Cemetery Oct. 19, 1930

20 UNDERTAKER

ADDRESS

Roy H. Barber Lanham, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Turner (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leuæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

DEC 6 1930

BUREAU

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Workman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



01832

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County

Montgomery

Registration Dist. No. 223

Village or City

Takoma Park, Wash. San. Hospital

St.:

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Baby Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Feb 22, 1930
(Month) (Day) (Year)

7 AGE

None mos. ds. or min.?

8 OCCUPATION

- (a) Trade, profession or particular kind of work
- (b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country)

Maryland

10 NAME OF FATHER

Harold D Smith

11 BIRTHPLACE OF FATHER
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Nettie E Scott

13 BIRTHPLACE OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harold D Smith

(Address)

630 Orpington Rd Baltimore Md

15

Filed

Feb 22

1930

H. H. Rogers

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb 22, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 22, 1930, to Feb 22, 1930, that I last saw her alive on Feb 22, 1930, and that death occurred on the date stated above, at 8:08 a. m.

The CAUSE OF DEATH * was as follows:

Premature separation of
Placenta
Probably 2 days
(Duration) yrs. mos. ds.Contributory
Secondary(Signed) Lauretta E. Kress M. D.
Feb 22, 1930 (Address) Takoma Park Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Baltimore, Md.

DATE OF BURIAL

Feb 22, 1930

20 UNDERTAKER

H. H. Rogers

ADDRESS

Wash. D. C.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

STATE OF MARYLAND
CERTIFICATE OF BIRTH

RECEIVED

RECEIVED
MAR 4 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery.

Village or City Germantown (No. _____)

2 FULL NAME Flim Sneed

03123 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2118

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH About 1930
(Month) (Day) (Year)

7 AGE 60? If LESS than 1 day ____ hrs. ____ yrs. ____ mos. ____ ds. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Va.

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (State or Country) "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Gertie Sidney.

(Address) Germantown Md.

15 Filed March 28 1930 Rachel Ware Etchison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 28 Mar, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 26 Mar 1930 to 28 Mar 1930 that I last saw him live on 26 Mar 1930 and that death occurred on the date stated above, at 8 a. m. The CAUSE OF DEATH * was as follows:

acute myocardial
(Duration) ____ yrs. ____ mos. 2 ds.

Contributory Secondary
(Signed) Stanley H. Zepher
28 Mar 1930 (Address) Germantown Md.

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

County Almshouse 29 March 1930

20 UNDERTAKER ADDRESS

Warner E. Humphrey Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever*, (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1930
BUREAU OF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Olney (No. _____)

2 FULL NAME Austin E. Snoots

03124 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE H. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Oct 1st 1873
(Month) (Day) (Year)

7 AGE 35 yrs. 5 mos. 17 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Soleman
(b) General nature of industry, business, or establishment in which employed or (employer) In free store

9 BIRTHPLACE (State or country) Va.

10 NAME OF FATHER Henry B. Snoots

11 BIRTHPLACE OF FATHER Va
(State or country)

12 MAIDEN NAME OF MOTHER Saura B Collins

13 BIRTHPLACE OF MOTHER Va
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm E. Snoots

(Address) 737 Park Road, D.C.

15 Filed Mar 18 1930 Mrs C. Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 18 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Mar 18 1930 to Mar 18 1930
that I last saw him alive on Mar 18 1930

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH * was as follows:

Accidental (auto)
Fracture of Vault of Skull
(Duration) ____ yrs. ____ mos. ____ ds. 16 hrs

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. B. Bird M. D.
Mar 18 1930 (Address) Sandy Spring, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? Mont Co. Md.

Former or usual residence 5919 Georgia Ave Wash D.C.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Washington D.C. Mar 18 1930

20 UNDERTAKER ADDRESS
John H. Wright Co. Wash. D.C.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

for issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

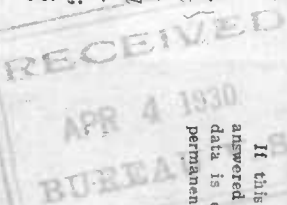
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leucæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING
WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Mont

05720 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Olney (No. Mont Co Gen Hosp) (St. MD) Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

² FULL NAME Richard P. Snowden

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 6, 1912
(Month) (Day) (Year)

7 AGE 18 yrs. mos. 5 ds. or min.? If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Labr
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) MD

10 NAME OF FATHER L. H. Snowden

11 BIRTHPLACE OF FATHER (State or country) MD

12 MAIDEN NAME OF MOTHER Lenett Snowden

13 BIRTHPLACE OF MOTHER (State or Country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard P. Snowden

(Address) Rockville MD

15 Filed May 13, 1930 C. J. Barnesley
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 11, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Apr 27, 1930 to May 11, 1930
that I last saw him alive on May 10, 1930

and that death occurred on the date stated above, at 12:30 a.m.
The CAUSE OF DEATH * was as follows:

General Septicaemia following Influenza

(Duration) yrs. 11 mos. 11 ds.

Contributory meningitis with abscess of thymoid
(Duration) yrs. mos. 3 ds.

(Signed) Charles Simpson M. D.

May 12, 1930 (Address) Sandy Spring, MD

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) Life

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Home (Rockville MD)

Former or usual residence Rockville R.D.

19 PLACE OF BURIAL OR REMOVAL Rockville Cemetery MD

DATE OF BURIAL 13, 1930

20 UNDERTAKER Roy W. Barbey

ADDRESS Sailorsburg

for issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds., *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

04481

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 212

Village or City Pooresville No. 31

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mabel H. Somersville

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) M

6 DATE OF BIRTH Nov 7, 1911
(Month) (Day) (Year)

7 AGE 32 yrs. 5 mos. 16 ds. If LESS than 1 day... hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Arthur Hall

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Ida Sykes

13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maurice Somersville

(Address) Pooresville

15 Filed Apr 24, 1930 E. W. White Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 23, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 23, 1929 to Apr 23, 1930, that I last saw her alive on Apr 21, 1930, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis
(Duration) 1 yrs. 0 mos. 0 ds.

Contributory
Secondary

(Signed) E. W. White Pooresville, Ind.
Apr 24, 1930 (Address) Pooresville, Ind.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Pooresville

20 UNDERTAKER

Harry Davis

DATE OF BURIAL

Apr 25, 1930

ADDRESS

Pooresville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; L. Pneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 6 1930

BUREAU

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1 PLACE OF DEATH
County Montgomery

Village or City Woodside Pk. (No. 45) Ga. Ave

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

2 FULL NAME Josephine Souder

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Jan. 16, 1862
(Month) (Day) (Year)

7 AGE 68 yrs. 10 mos. 4 ds. If LESS than 1 day ___ hrs. or ___ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None.
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Wash. D.C.

10 NAME OF FATHER Joseph Phillips

11 BIRTHPLACE OF FATHER (State or country) England

12 MAIDEN NAME OF MOTHER Martha Schloffer

13 BIRTHPLACE OF MOTHER (State or Country) Wash. D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sadie M. Williams

(Address) Ga. Ave. Woodside Pk. Ind. Wash. D.C.

15 Filed Nov. 20, 1927 F. E. Dudley, Jr.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 20, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov. 13, 1930 to Nov. 20, 1930, that I last saw him alive on Nov. 19, 1930, and that death occurred on the date stated above, 12:30 A. M. The CAUSE OF DEATH * was as follows:

mitral stenosis

(Duration) 10 yrs. ___ mos. ___ ds.
Contributory Intestinal Carcinoma
Secondary

(Duration) 6 yrs. ___ mos. ___ ds.
(Signed) R. Cleaver Cook M. D.
Nov. 20, 1930 (Address) 1223 Vermont St. Wash. D.C.

*State the Disease Causing Death, or, if Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Nov. 21, 1930

20 UNDERTAKER

ADDRESS

Thos. S. Sargent Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugstician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

1930
61
69
Mr. Cook
Records 603

DEC 8 1930

BUREAU

RECEIVED

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Gaithersburg (No. _____)2 FULL NAME Charles A. Spates

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Apr 27th 1854
(Month) (Day) (Year)

7 AGE 76 yrs. 1 mos. 19 ds. or min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Contractor (Painter)
(b) General nature of industry business, or establishment in which employed or (employer) Painting

9 BIRTHPLACE (State or country) Rockville Md

10 NAME OF FATHER John W. Spates

11 BIRTHPLACE OF FATHER (State or country) Rockville Md

12 MAIDEN NAME OF MOTHER Anna Gyllon

13 BIRTHPLACE OF MOTHER (State or Country) Rockville Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. G. Duley(Address) 5625-8th St. NW,

15 Filed June 17 1930 Washington D.C.
Basel One Edition
Registrar

06852

(90)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 15, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 7, 1930 to June 15, 1930.

that I last saw him alive on June 15, 1930.

and that death occurred on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH * was as follows:

Acute Cardiac Dilatation

(Duration) ____ yrs. ____ mos. 1 ds.

Contributory Chronic cardio-renal disease
Secondary

(Duration) 2 yrs. ____ mos. ____ ds.

(Signed) J. J. Bronckart M. D.

6-17-30 (Address) Gaithersburg Md

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rockville, Md DATE OF BURIAL June 17, 1930

20 UNDERTAKER W. R. Pumphrey Jr. ADDRESS Rockville, Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUL 7 1930
BUREAU

MARGIN RESERVED FOR BINDING

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Poolesville

(No. _____)

St. _____

Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Richard Fremont Spates

01833

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

widowed

6 DATE OF BIRTH

May

17

1850

(Month)

(Day)

(Year)

7 AGE

77 yrs.

9 mos.

7 ds.

If LESS than
1 day _____ hrs.
or _____ min.?

8 OCCUPATION

(a) Trade, profession or
particular kind of work

Farmer

(b) General nature of industry
business, or establishment in
which employed or (employer)

9 BIRTHPLACE

(State or country)

Montgomery Co. Md

10 NAME OF
FATHER

Geo Washington Spates

11 BIRTHPLACE
OF FATHER

(State or country)

Montgomery Co. Md

12 MAIDEN NAME
OF MOTHER

Nancy Boyd Kuehls

13 BIRTHPLACE
OF MOTHER

(State or Country)

Montgomery Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Roger Spates

(Address)

Rockville, Md.

15 Filed

Feb 11

1920

E W White

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Feb

10

1920

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Feb 8

1920

to

Feb 10

1920

that I last saw him

alive on

Feb 9

1920

and that death occurred on the date stated above, at 1 a. m.

The CAUSE OF DEATH * was as follows

arteriosclerosis

Contributory
Secondary

(Duration)

3 yrs.

mos.

ds.

(Duration)

3 yrs.

mos.

ds.

(Signed)

E W White

M. D.

Feb 11

1920

(Address)

Poolesville

*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-
ients or Recent Residents)At place
of death

yrs.

mos.

ds.

In the
State

yrs.

mos.

ds.

Where was death contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Monocacy Cemetery

Feb. 11, 1920

20 UNDERTAKER

ADDRESS

Hilton & Hall

Poolesville Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
MAR 5 1900
BUREAU

WRITE PENCIL WITH UNFADING INK---THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Village or City

(No.)

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

12567 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2-16

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than
1 day.....hrs.
1 day.....hrs.
1 day.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

10-25-1930 Thomas J. Louder

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 25, 1920
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from
March 1, 1920, to Oct 25, 1920.

That I last saw him alive on Oct 20, 1920

and that death occurred on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH * was as follows:

Myocarditis

(Duration) 1 yrs. 1 mo. 1 da.

Contributory
Secondary

Coronary thrombosis

(Duration) 1 yrs. 1 mo. 1 da.

(Signed) Chas. Bliss M. D.

Oct 25, 1920 (Address) The Remond House

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

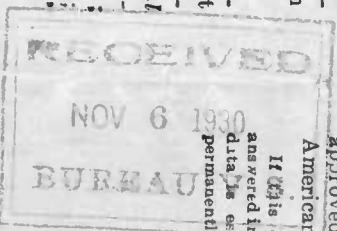
(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc.*, *Carcinoma, Sarcoma, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Montg.

Village or City

Takoma Park, Ind Wash Saw St. Hospital

2 FULL NAME

Sperry, Clarence BSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Oct101870

(Month)

(Day)

(Year)

7 AGE

60 yrs.2 mos.9 ds.If LESS than
1 day.....hrs.
or.....min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

W. Va

10 NAME OF FATHER

E. C. Sperry

11 BIRTHPLACE OF FATHER

(State or country)

N. Y.

12 MAIDEN NAME OF MOTHER

Mary Patton

13 BIRTHPLACE OF MOTHER

(State or country)

W. Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Record

(Address)

15 Filed

Dec 19, 19301930H. E. Rogers
Registrar

16 DATE OF DEATH

Dec. 1919230

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Dec 121930to Dec 191930

that I last saw him alive on

Dec 191930and that death occurred on the date stated above, at 2:45 P.m.

The CAUSE OF DEATH * was as follows:

Uremic Toxemia

(Duration)

yrs.

mos.

ds.

Contributory
SecondaryChronic Nephritis

(Duration)

yrs.

mos.

ds.

(Signed)

D. J. Kless

M. D.

Dec 19 1930

(Address)

Takoma Park, Dc

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death

yrs.

mos.

7 ds.

In the State

yrs.

mos.

23 ds.

Where was disease contracted, if not at place of death?

231Day & ClarkburgW. Va.

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Clarksburg W. Va

DATE OF BURIAL

Dec 19 21 1930

20 UNDERTAKER

H. E. Rogers

ADDRESS

Wash. D. C.

RECEIVED

JAN 3 1931

BUREAU V

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montg.

05721

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

Village or City

Cherry Chase

(No. 5)

Leland St.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Emily S. P. Stearns

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, ☒ MARRIED, ☒ WIDOWED, ☒ OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Sept. 9th, 1852
(Month) (Day) (Year)

7 AGE

77 yrs. 8 mos. 26 ds. or min. ?
If LESS than 1 day.... hrs. ?

8 OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

N. York City

10 NAME OF FATHER

Charles Palmer

11 BIRTHPLACE OF FATHER
(State or country)

N.Y. City

12 MAIDEN NAME OF MOTHER

Sarah Somers

13 BIRTHPLACE OF MOTHER
(State or country)

N.Y. City

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. P. N. Stearns

(Address)

Valley Vista App.

15

Filed

5-13-1930 Thomas K. Lomax
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 13, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Feb. 6, 1930, to May 13, 1930.

that I last saw him alive on May 13, 1930.

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH was as follows:

Cerebral Embolism

Contributory
Secondary3 hrs.
(Duration) yrs. mos. ds.

Mitral Valvular Infection

(Signed) Thomas K. Lomax M.D.

5-15-1930 (Address) Thomas K. Lomax

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal. Cherry Chase, Md.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death... yrs. ... mos. ... da. In the State... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hollywood Cem. Richmond Va. 5/15/1930

20 UNDERTAKER

W. R. Tabler

ADDRESS

Wash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia").

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 6 1930

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			06026 STATE OF MARYLAND CERTIFICATE OF DEATH		Registration Dist. No. 212	
County <u>Montg.</u>			188-C			
Village or City <u>Near Martinsburg</u> (No. _____, _____ St.; _____ Ward)			(If death occurred in a hospital or institution, give its NAME instead of street and number.)			
2 FULL NAME <u>Homer Stocks</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, <u>Widowed</u> MARRIED, WIDOWED OR DIVORCED (Write the word)				
6 DATE OF BIRTH _____, _____, 192____ (Month) (Day) (Year)						
7 AGE <u>about 38</u> If LESS than 1 day.... hrs. _____ yrs. mos. da. or min. ?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farm laborer</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____						
9 BIRTHPLACE (State or country) <u>Virginia</u>						
10 NAME OF FATHER <u>George Stocks</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>						
12 MAIDEN NAME OF MOTHER <u>Margaret Stocks</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wallace Stocks</u> (Address) <u>Lucketts, Va.</u>						
15 Filed <u>May 31</u> 192 <u>3</u> <u>Mrs. C. C. Shelton</u> Registrar <u>E. W. White</u>						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>May 31</u> - 192 <u>3</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from _____, 192____, to _____, 192____, that I last saw him alive on _____, 192____, and that death occurred on the date stated above, at _____m. The CAUSE OF DEATH was as follows: <u>Fracture of skull: automobile accident, auto while overturning near Martinsburg, Montg. County, Va.</u> Contributory <u>Accident</u> Secondary _____ (Duration) <u>Did the same day.</u> yrs. mos. da. (Signed) <u>T. R. Gandy</u> M. D. <u>May 31</u> 192 <u>3</u> (Address) <u>Barnesville</u> State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. da. In the State, yrs. mos. da. Where was disease contracted, if not at place of death? _____ Former or usual residence _____						
19 PLACE OF BURIAL OR REMOVAL <u>Lucketts Va.</u> DATE OF BURIAL <u>6/2</u> 192 <u>3</u>						
20 UNDERTAKER <u>W. O. Hillon</u> ADDRESS <u>Barnesville</u>						
If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1 <u>mm</u>						

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. *As examples:* (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed, or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 30 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is filled over thoroughly and all questions answered in detail, it will prevent further correspondence. If the data is essential and must be obtained before the certificate is permanently filed.

100-2 1930
BUREAU V.S.

MARGIN RESERVED FOR BINDING
WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County MontgVillage or City Gaithersburg (No. _____)2 FULL NAME Laura Virginia StonebrakerSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218(If death occurred in a hospital or institution, give its NAME instead of street and number.)
St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)6 DATE OF BIRTH Aug 3rd 1849
(Month) (Day) (Year)7 AGE 81 yrs. 4 mos. 17 ds. or min. If LESS than 1 day ____ hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER John Schaeffer11 BIRTHPLACE OF FATHER (State or country) Md12 MAIDEN NAME OF MOTHER Mary Hershey13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs David Hershey
(Address) Gaithersburg Md15 Filed 12-22-30 Reed Lee & Tolison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12-20-1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 7-28-30 192__ to 1930that I last saw him alive on 12-20-1930and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH was as follows:

Cholelithiasis and cholecystitis(Duration) 5 yrs. 5 mos. 5 ds.Contributory
Secondary(Signed) W. C. Miller M. D.
12-22-30 (Address) Gaithersburg, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 5 yrs. 5 mos. 5 ds. In the State 5 yrs. 5 mos. 5 ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rose Hill cemetery Hagerstown Md DATE OF BURIAL Dec 23rd 193020 UNDERTAKER E. E. Galt ADDRESS Gaithersburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Doy laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Pumpkin breeder 6 yrs*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

JAN 6 1931

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

*typing & me
revised index
1931*

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¹PLACE OF DEATH
County NTG

Village or City Coleville (No. _____)

²FULL NAME No name Stoneburne

05722

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH May 29 1930
(Month) (Day) (Year)

7 AGE _____ If LESS than 1 day 11 hrs.
_____ yrs. _____ mos. _____ ds. or _____ min.

8 OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Coleville

10 NAME OF FATHER John R Stoneburne

11 BIRTHPLACE OF FATHER VA
(State or country)

12 MAIDEN NAME OF MOTHER Pauline E Burroughs
Hedrick Miller

13 BIRTHPLACE OF MOTHER NTG MD
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John R Stoneburne
(Address) Coleville MD

15 Filed May 30 1930 F B Wadley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 30 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from May 29 1930 to May 30 1930, that I last saw her alive on May 29 1930

and that death occurred on the date stated above, at 5 A. m.
The CAUSE OF DEATH * was as follows:

Heart dilatation of heart.
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory Premature infant.
Secondary
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. R. Hayner M. D.
May 30 1930 (Address) Silver Spring MD

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Forest Glen Cemetery DATE OF BURIAL May 31 1930
Forest Glen

20 UNDERTAKER John R Stoneburne ADDRESS Coleville MD

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 7 12:00
BUREAU V. S.

N. B. Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg. Co.

Village or City Silver Spring (No. _____)

2 FULL NAME LILLIAN STONER,

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Feb. 4 1859
(Month) (Day) (Year)

7 AGE 71 8 16
yrs. mos. ds. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Government Clerk,
(b) General nature of industry business, or establishment in which employed or (employer) U S. Gov't.

9 BIRTHPLACE (State or country) Indiana.

10 NAME OF FATHER No Record,

11 BIRTHPLACE OF FATHER (State or country) No Record,

12 MAIDEN NAME OF MOTHER No Record,

13 BIRTHPLACE OF MOTHER (State or country) No Record,

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Record,

(Address) Maplewood Sanitarium,
Silver Sp. Md.

15 Filed Oct 20 1930 J. E. Wadley Jr.
Registrar

12568

(75-a)

Maplewood San.
Maryland.

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Disa. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 20 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 17 1929 to Oct 20 1930
that I last saw him alive on Oct 15 1930

and that death occurred on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH * was as follows:

Hemiplegia producing paralysis
of right side. Cardiac asthma
(Duration) 1 yrs. 1 mos. 3 ds.

Contributory Arterio sclerosis
Secondary
(Duration) 5 yrs. 1 mos. 3 ds.

(Signed) Harry O. Smith M. D.
Oct 20, 1930 (Address) 1524 P St N.W.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 8 mos. 8 ds. In the State Washington D.C. yrs. mos. ds.

Where was disease contracted, if not at place of death? Washington D.C.

Former or usual residence Washington D.C.

19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL Oct. 20, 1930

20 UNDERTAKER Martin W. Byington ADDRESS #1300 N St. N.W.

(Approved by U. S. Census and American Public Health Association.)

NOV 7 1930

BUREAU V. 3.

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE MAIN, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Rockville (No. _____)

2 FULL NAME Margie Lee Sudduth

03125

(46)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Dec 4, 1894
(Month) (Day) (Year)

7 AGE 36 yrs. 3 mos. 25 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Kentucky

10 NAME OF FATHER Albert. Hall

11 BIRTHPLACE OF FATHER (State or country) Rockville Md

12 MAIDEN NAME OF MOTHER Lee. Humphrey

13 BIRTHPLACE OF MOTHER (State or Country) Rockville Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. G. B. Terry
(Address) Rockville Md.

15 Filed 4-1 19230 Mrs. W. T. Platt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 29, 19230
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 20 1929 to Mar 29, 1920

that I last saw her alive on Mar 29, 1920

and that death occurred on the date stated above, at 1145 m.

The CAUSE OF DEATH * was as follows:

Carcinoma of Uterus
metastatic

(Duration) ____ yrs. 3 mos. ____ ds.

Contributory Secondary Drunk

(Signed) O. S. Davis M. D.
Mar 30 19230 (Address) Rockville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville Union Cemetery DATE OF BURIAL Apr 1, 19230

20 UNDERTAKER W. R. Humphrey Jr ADDRESS Rockville Md

(Approved by U. S. Census and American Public Health Association.)

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PARTICULARS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

04482

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Alney (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Amir Z. Sullivan Montg. Jan 16/95

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE N. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single.
(Write the word)

6 DATE OF BIRTH 1/4/1930
(Month) (Day) (Year)

7 AGE 73 yrs. 4 mos. 4 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ms

10 NAME OF FATHER Robert M. Sullivan

11 BIRTHPLACE OF FATHER (State or country) Ms.

12 MAIDEN NAME OF MOTHER Marcella Thomas

13 BIRTHPLACE OF MOTHER (State or country) Ms.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marcella Thomas

(Address) Sandy Spring Ms

15 Filed April 4 1930 C. S. Barnard Registrar

See issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4/3/1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 4/1/1930 to 4/3/1930, that I last saw him alive on 4/3/1930, and that death occurred on the date stated above, at 10 a m.

The CAUSE OF DEATH * was as follows:

Supper

Contributory (Duration) yrs. mos. ds. 6
Secondary Broncho-pneumonia

(Signed) J. M. B. M. D. 4/4/1930 (Address) Sandy Spring Ms

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. 5 In the State yrs. mos. ds. 5

Where was disease contracted, if not at place of death? At home

Former or usual residence Edmon

19 PLACE OF BURIAL OR REMOVAL Woodside DATE OF BURIAL 4/5/1930

20 UNDERTAKER W. K. Humphrey ADDRESS Rockville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

MAY 6 1930
BUREAU V. B.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgo

Village or City

Alney

(No.

2 FULL NAME

Sousar B. Sullivan

 15181 STATE OF MARYLAND
 CERTIFICATE OF DEATH

Registration Dist. No.

217

St. Ward

 (If death occurred in
 a hospital or institu-
 tion, give its NAME in-
 stead of street and
 number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

 5 SINGLE,
 MARRIED,
 WIDOWED,
 OR DIVORCED
 (Write the word)

Single

6 DATE OF BIRTH

 5 - 24 - 1989
 (Month) (Day) (Year)

7 AGE

21 yrs. 7 mos. ds. or min.?

 If LESS than
 1 day hrs.

8 OCCUPATION

 (a) Trade, profession or
 particular kind of work

Mail (house)

 (b) General nature of industry
 business, or establishment in
 which employed or (employer)

9 BIRTHPLACE

(State or country)

Va.

10 NAME OF
FATHER

Sousar T. Sullivan

11 BIRTHPLACE

OF FATHER

(State or country)

Va.

12 MAIDEN NAME

OF MOTHER

Sousar B. Fletcher

13 BIRTHPLACE

OF MOTHER

(State or country)

Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. Sousar B. Fletcher

(Address)

Spottsylvania Va.

15

Filed

Dec 25, 1988 CB Banksley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

 12/24/1989
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

 12/15/1989 to 12/24/1989
 that I last saw him alive on 12/24/1989

 and that death occurred on the date stated above, at 9 a. m.
 THE CAUSE OF DEATH * was as follows:

 Sun shot wound of abdomen
 suicidal cause

(Duration) yrs. mos. ds.

Contributory
Secondary

Pneumonia

(Duration) yrs. mos. ds.

(Signed) J. J. J. M. D.

12/24/1989 Address Sandy Spring Md

 *State the Disease Causing Death, or, in deaths from
 Violent Causes, state (1) Means of Injury and (2) Whether
 Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

 At place
 of death yrs. mos. ds.

 In the
 State yrs. mos. ds.

 Where was disease contracted,
 if not at place of death?
Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mint Run Va.

12/27/1989

20 UNDERTAKER

ADDRESS

Karnes & Humphrey Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

fee issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Colon mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by tartaric acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

This certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data are essential and must be obtained before the certificate is permanently filed.

RECEIVED

JAN 3 1931

BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

09398

(90)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Near Bethesda (No. - Wilson Lane)

St.: _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John Henry Sumner

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>
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6 DATE OF BIRTH June 30th 1900
(Month) (Day) (Year)7 AGE 30 yrs. 2 mos. 15 ds. or LESS than 1 day hrs. min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Auto mechanic
(b) General nature of industry, business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) England
10 NAME OF FATHER William Sumner

PARENTS	11 BIRTHPLACE OF FATHER (State or country) <u>England</u>
	12 MAIDEN NAME OF MOTHER <u>Mary Rowe</u>
	13 BIRTHPLACE OF MOTHER (State or Country) <u>England</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. C. Sumner
(Address) Bethesda, Md.15 Filed Aug. 26 1930 Benj. C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 25, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from December 1929 to Aug 24, 1930
that I last saw him alive on Aug 24, 1930and that death occurred on the date stated above, at 9:30 P. M.
The CAUSE OF DEATH * was as follows:Chronic dilatation of heartContributory
Secondary
(Duration) _____ yrs. _____ mos. _____ ds.(Signed) Benj. C. Perry M. D.
8/26 1930 (Address) Bethesda, Md.

*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Union Cemetery-Rockville DATE OF BURIAL Aug 28, 193020 UNDERTAKER Warner E. Pumphrey ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.*" State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Near Rockville

2 FULL NAME

*Summerour*STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

213

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Coloured

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

November 11, 1930

(Month) (Day) (Year)

7 AGE

2 yrs. *2* mos. *2* ds. or min.?

If LESS than 1 day hrs. min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Rockville Md

10 NAME OF FATHER

Sherman Summerour

11 BIRTHPLACE OF FATHER

(State or country)

Georgia

12 MAIDEN NAME OF MOTHER

Ida Israel

13 BIRTHPLACE OF MOTHER

(State or Country)

Georgia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sherman Summerour

(Address)

Rockville, Md.

15

Filed

Nov 13

1930

Mrs. H. T. Ball

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 12, 1930

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

*Nov. 11, 1930 to Nov. 12, 1930*that I last saw her alive on *Nov. 12, 1930*and that death occurred on the date stated above, at *4 P.* m.

The CAUSE OF DEATH * was as follows:

Prematurity (7 mos - 2 1/2 lb.)

(Duration) yrs. mos. ds.

Contributory Secondary

None

(Duration) yrs. mos. ds.

(Signed)

*Wm. D. Summerour M. D.**Nov. 12, 1930 (Address) Rockville, Md.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Lincoln Park**11/13, 1930*

20 UNDERTAKER

ADDRESS

*Sherman Summerour**Rockville, Md.*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Pajotier, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

DEC 2 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomerySTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 2/3Village or City Glen Echo (No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Thomas E. Sweeney

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
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6 DATE OF BIRTH
November 7, 1858
(Month) (Day) (Year)7 AGE
72 yrs. 1 mos. 24 ds. or _____ min.?
If LESS than 1 day _____ hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Bugologist
(b) General nature of industry business, or establishment in which employed or (employer) Govt. Research9 BIRTHPLACE (State or country)
New York10 NAME OF FATHER
John Sweeney11 BIRTHPLACE OF FATHER (State or country)
Ireland12 MAIDEN NAME OF MOTHER
Rebecca Reddick13 BIRTHPLACE OF MOTHER (State or country)
New Jersey

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Maude B. Sweeney(Address) Glen Echo, Md.15 Filed 12/19/31 192 Mrs. H. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 31, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Dec. 28 1930 to Dec. 31, 1930, that I last saw him alive on Dec. 28, 1930.and that death occurred on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH * was as follows:

Cerebral HemorrhageContributory
Secondary(Signed) F. M. McChesney M. D.
Jan. 2 1931. (Address) 3421 7th Avenue

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Englewood, N. J.

DATE OF BURIAL

Jan. 5th, 1931

20 UNDERTAKER

ADDRESS

Warner E. Pumphrey Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and, also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc.,* of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 8 1931

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RECEIVED
JUN 7 1930
BUREAU V. S.

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1299

1 214 51
1 5 11 4
1 1 1 1 1 1 1

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory
Secondary

(Signed)

(Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

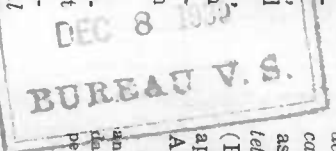
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

08178

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *223*

Village or City

Takoma Park (No. *Trach Sany Hospital*)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Elio Marie Tempel

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

July 22nd 1930
(Month) (Day) (Year)

7 AGE

If LESS than

1 day..... hrs.

..... yrs. mos. ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

none

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF FATHER

Clifford Morley Tempel

11 BIRTHPLACE OF FATHER

(State or country)

New Zealand

12 MAIDEN NAME OF MOTHER

Ivanilla Juanita Snow

13 BIRTHPLACE OF MOTHER

(State or country)

California

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clifford Morley Tempel

(Address)

126 Carroll Ave

15

Filed

July 22 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 22nd 1930
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended the deceased from

July 22nd 1930 to *July 22nd 1930*that I last saw her alive on *July 22nd 1930*and that death occurred on the date stated above, at *12:30* m.

The CAUSE OF DEATH * was as follows:

*Eclampsia of mother
caused asphyxiation Embryo*

(Duration) yrs. mos. ds.

Contributory
Secondary*Albuminuria*

(Duration) yrs. mos. ds.

(Signed)

Rouvenna E. Kress

M. D.

July 22, 1930

(Address)

Takoma Park - Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death..... yrs. mos. ds.

In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cedar Hill Cem**July 23 1930*

20 UNDERTAKER

ADDRESS

*H. B. Rowins**924 N. Y Ave. Md.*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (c) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cardiopycnetal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, "PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 5 1930
BUREAU

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomerySTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218Village or City Gaithersburg (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Elenore Virginia Terry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH June 1, 1896
(Month) (Day) (Year)7 AGE 34 yrs. 0 mos. 27 ds. If LESS than 1 day ____ hrs. or ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER George Wims11 BIRTHPLACE OF FATHER (State or country) Md.12 MAIDEN NAME OF MOTHER Lillie M. Randolph13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillie M. Randolph(Address) Gaithersburg Md15 Filed June 30 1930 Nachel D. A. Nelson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 28, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from June 28, 1930 to June 28, 1930, that I last saw him alive on June 28, 1930, and that death occurred on the date stated above, at 9:30 p. m.

The CAUSE OF DEATH * was as follows:

Unknown died suddenly while attending a picnic. Cross from a table looked less than 1/2 hr. ill and slumped to floor, dying in less than 15 min. Contributory Secondary half on hour. Cerebral.(Signed) W. C. Miley M. D. 6-30-30 (Address) Gaithersburg, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockey Hill July 2, 1930

20 UNDERTAKER

ADDRESS

E. B. Gaitner Gaithersburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

JUL 7 1930
BUREAU V. 30

MARGIN RESERVED FOR BINDING
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County MonVillage or City Norwood (No.)2 FULL NAME Adolphus H Thomas

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Mar6 DATE OF BIRTH Aug 17th 1869 (Month) (Day) (Year)7 AGE 60 yrs. 11 mos. 22 ds. If LESS than 1 day hrs. or min.?8 OCCUPATION
(a) Trade, profession or particular kind of work assistant to undertaker
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) MD10 NAME OF FATHER Ben. F. Thomas11 BIRTHPLACE OF FATHER (State or country) MD12 MAIDEN NAME OF MOTHER Martha Ann Holland13 BIRTHPLACE OF MOTHER (State or country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard Thomas(Address) Sandy Spring Md15 Filed Aug 10 1930 C. B. Brunsley Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

09399

(31)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 7th 1930 (Month) (Day) (Year)17 I HEREBY CERTIFY That I attended the deceased from Aug 5th 1930 to Aug 7th 1930 that I last saw him alive on Aug 6th 1930 and that death occurred on the date stated above, at 4:30 P.m. The CAUSE OF DEATH * was as follows:Pulmonary Tuberculosis(Duration) unknown yrs. mos. ds.Contributory Chest injury / accidental(Duration) 1 yrs. 3 mos. ds.(Signed) C. C. Smiles M. D.
Aug 8 1930 (Address) Sandy Spring Md

*State the disease causing death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandy Spring Md - Aug 10th 193020 UNDERTAKER ADDRESS
Geo Snowden Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*; and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremie," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Near Chain Bridge (Autopsy at Rockville)

(No.)

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

John Benson ThomasSTATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

216

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)Married

6 DATE OF BIRTH

March91887

(Month)

(Day)

(Year)

7 AGE

43

yrs.

7

mos.

6

ds.

If LESS than
1 day ____ hrs.
or ____ min.?

8 OCCUPATION

(a) Trade, profession or
particular kind of workReal Estate(b) General nature of industry
business, or establishment in
which employed or (employer)""

9 BIRTHPLACE

(State or country)

D.C.10 NAME OF
FATHERJoseph B. Thomas11 BIRTHPLACE
OF FATHER

(State or country)

Ind12 MAIDEN NAME
OF MOTHERMary C. Cooper13 BIRTHPLACE
OF MOTHER

(State or Country)

D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John B. Thomas

(Address)

#1 Thomas Circle D.C.

15

Filed

6/17

1920

Benj C. Perry

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

about Aug 151930August

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

Found dead Aug 151930

that I last saw him alive on _____, 192____,

and that death occurred on the date stated above, at _____m.

The CAUSE OF DEATH * was as follows:

Chronic Nycocarditis

(Duration)

UnknownContributory
SecondaryChr interstitial Hepatitis

(Duration)

____yrs. ____mos. ____ds.

(Signed)

M. J. Pratt

M. D.

Aug 16

1920

(Address) Rockville Ind*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-
ients or Recent Residents)

At place of death

About one week

In the

State ____yrs. ____mos. ____ds.

Where was disease contracted,
if not at place of death?Former or
usual residenceWashington D.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Glenwood Cemetery, D.C.Aug 181930

20 UNDERTAKER

ADDRESS

Marner E. PumphreyRockville Ind

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

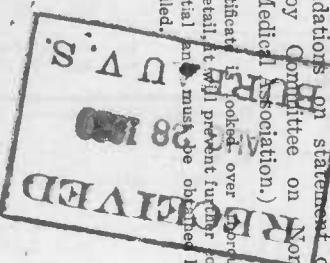
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Silver Spring (No. _____)

2 FULL NAME Thomas, Rosa Hort

15183

48

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Oct 12, 1852
(Month) (Day) (Year)

7 AGE 78 yrs. 1 mos. 23 ds. or min.?
If LESS than 1 day... hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Philadelphia, Pa

10 NAME OF FATHER Herman Hort

11 BIRTHPLACE OF FATHER (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Anne Maria Bauer

13 BIRTHPLACE OF MOTHER (State or country) Switzerland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. Virginia Danickiewicz

(Address) Silver Spring, Md

15 Filed Dec. 5, 1930 J. E. Wadley
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 5, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 24, 1929 to Dec 5, 1930, that I last saw him alive on Dec. 4, 1930, and that death occurred on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH * was as follows:

Epithelioma of face

(Duration) 15 yrs. mos. ds.

Contributory
Secondary

(Duration) 15 yrs. mos. ds.

(Signed) W. Mitchell M. D.
Dec 5, 1930 (Address) Silver Spring, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL 12-5-30

20 UNDERTAKER J. H. Hines Co ADDRESS 2901-14th St.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrotypical fever* (the only definite synonym is "Epidemic cerebro-signal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 5 1931

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

09401

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Cothran (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME, extend of street and number.)

2 FULL NAME David H. Thompson Jr.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE Celms 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Unknown (Month) _____ (Day) _____ (Year) _____

7 AGE 38 yrs. Unknown ds. or min. If LESS than 1 day _____ hrs.

8 OCCUPATION (a) Trade, profession or particular kind of work Solomon (b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER David H. Thompson

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Eleabeth Williams

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) _____

15 Filed Aug 13 1920 Cl Barnsby Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8/10/1920 (Month) _____ (Day) _____ (Year) _____

17 I HEREBY CERTIFY, That I attended the deceased from autopsy on Aug 10, 1920, that death occurred at Cothran, Md.

and that death occurred at Cothran, Md. m.

The CAUSE OF DEATH * was as follows:

Heart emboled to Montpelier
Hospital
Ruptured Spleen
Automobile
Contributory Secondary
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) [Signature] M. D.
8/10/1920 (Address) Sandy Spring

*State the 1st cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Sandy Spring DATE OF BURIAL 8-13-20

20 UNDERTAKER Test H. Morden ADDRESS Rockville

for issued

md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptoms), "Debility" ("Congenital," "Senile," etc.), "Convulsions," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Lakewood Park

2 FULL NAME

*George B. Thompson*STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *228*

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

*W*5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Sept. 24, 1862
(Month) (Day) (Year)

7 AGE

67 yrs. *9* mos. *27* ds. or min.?If LESS than
1 day hrs.
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Clergyman

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country)*Indiana*10 NAME OF
FATHER*John Thompson*11 BIRTHPLACE
OF FATHER

(State or country)

*Scotland*12 MAIDEN NAME
OF MOTHER*Catherine Costello*13 BIRTHPLACE
OF MOTHER

(State or country)

Scotland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. G. B. Thompson

(Address)

106 Park Ave Takoma Park, D.C.

15

Filed

*June 21, 1930**H. E. Rogers*

Registrar

16 DATE OF DEATH

6/21, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from
March 1930 to *June 19, 1930*that I last saw him alive on *June 19, 1930*and that death occurred on the date stated above, at *7 a.m.*
The CAUSE OF DEATH * was as follows:*Cerebral - apoplexy*(Duration) *6* yrs. mos. ds.Contributory
Secondary*Cerebral apoplexy*

(Duration) yrs. mos. ds.

(Signed) *Frank R. Williams* M. D.*6/21/1930* (Address) *2731 Wisconsin Ave Wash. D.C.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Wash. D.C.**June 24, 1930*

20 UNDERTAKER

ADDRESS

*K. B. Munn**Wash. D.C.*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary; or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a 1 quations answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUL 5 1900
BUREAU V.S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County *Montgomery*Village or City *Woodfield* (No. _____)2 FULL NAME *Millard Eugene Thompson*STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *211*

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *H.* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*
(Write the word)6 DATE OF BIRTH *Nov. 11 1856*
(Month) (Day) (Year)7 AGE *73 yrs. 11 mos. 21 ds.* If LESS than 1 day ____ hrs. or ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work *Retired Farmer*
(b) General nature of industry, business, or establishment in which employed or (employer)9 BIRTHPLACE
(State or country) *Md.*10 NAME OF FATHER *Columbus Thompson*11 BIRTHPLACE OF FATHER
(State or country) *Md.*12 MAIDEN NAME OF MOTHER *Sarah Ann Burns*13 BIRTHPLACE OF MOTHER
(State or country) *Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Mrs. Julia Thompson*(Address) *R. D. Fairthursbury, Md.*15 Filed *Oct 7 1921* *Della W. Beall*
Deft. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct. 3 1930*
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *November 1929* to *Oct. 3 1930*.that I last saw him alive on *Oct. 2 1930*,and that death occurred on the date stated above, at *345 a. m.*The CAUSE OF DEATH * was as follows:
Carcinoma of Stomach(Duration) *2 yrs. or longer* ds.Contributory
Secondary(Signed) *George M. Boyer* M. D.
Oct 4 1930 (Address) *Damascus, Md.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence:

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Bahart Cemetery *Oct 7 1930*

20 UNDERTAKER

ADDRESS

Roy H. Barber *Lyonsville, Md.*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 5 1930

BUR

WRITE INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

10557

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

217

Village or City

Rockville

(No.)

St.

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Ruth Matilda Thompson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

2 - 26 - 1886
(Month) (Day) (Year)

7 AGE

73 yrs. 6 mos. 19 ds. or min.?

If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md.

10 NAME OF FATHER

John Thompson

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Margaret A. Murphy

13 BIRTHPLACE OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Matilda A. Bumpus

(Address)

Rockville

15 Filed

Sept 17 1938 C. S. Barnsley

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

9/15/1938

1938

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended the deceased from

2/1/1928

to

9/15/1938

1938

that I last saw him alive on 9/5/1938.

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Coronary Arteriosclerosis

(Duration)

5 yrs.

mos. ds.

Contributory Secondary

Coronary Arteriosclerosis

(Duration)

1 yrs.

mos. ds.

(Signed)

J. S. Bumpus

M. D.

9/17/1938

(Address)

Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Burlington Cem.

Sept 17, 1938

20 UNDERTAKER

ADDRESS

Ruben Bumpus

Rockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pastrycook, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sprinter, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonocum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, its fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 4 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

13940

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

Village or City Olney (No. Mont & Gen Hosp St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby Timbers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH Nov 9th, 1930
(Month) (Day) (Year)

7 AGE yrs. mos. ds. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) ind -

10 NAME OF FATHER Tom J. Timbers

11 BIRTHPLACE OF FATHER (State or country) Va - Rockville

12 MAIDEN NAME OF MOTHER Elsie Diggs

13 BIRTHPLACE OF MOTHER (State or country) Ind - Rockville

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elsie D Timbers
(Address) Rockville Md

15 Filed Nov 10, 1930 C. S. Barnsley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 9th, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Nov 9th, 1930 to Nov 9th, 1930
that I last saw her dead on Nov 9th, 1930,
and that death occurred on the date stated above, at 6:10 a. m.
The CAUSE OF DEATH * was as follows:

Stillbirth

(Duration) yrs. mos. ds.
Contributory autoaccident
Secondary (Duration) yrs. mos. 5 ds.

(Signed) C. S. Barnsley M. D.
Nov 10, 1930 (Address) Sandy Spring

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death yrs. mos. 1 ds. In the life State yrs. mos. ds.

Where was disease contracted, if not at place of death?
Former or usual residence Rockville Md

19 PLACE OF BURIAL OR REMOVAL County Home DATE OF BURIAL Nov 10th, 1930

20 UNDERTAKER Warner Humphrey ADDRESS Rockville

for resumed

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

DEC 3 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory," or Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

66855

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

1 PLACE OF DEATH

County

Village or City

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day hrs.
or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

General atherosclerosis
Chronic nephritis
Chronic myocarditis

(Duration) 2 yrs. 1 mos. 15 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) James F. Davidson M. D.

6/15 1923 (Address) 203 Elm Chry. Chas. Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Seaman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At School, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mastitis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mastitis (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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JUL 5 1929
BUREAU

1929
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1843
9

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Md.

Village or City Belts Spring Md. (No. 44)

Maplewood San. St. Ward

Registration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Joseph A Tolly

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Jan 26, 1852
(Month) (Day) (Year)

7 AGE 78 yrs. 3 mos. 6 ds. IF LESS than 1 day hrs. min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work School Teacher
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER James Walter Tolly

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Julian Howland

(Address) Belts Spring Md.

15 Filed May 2, 1930 J. E. Dooling Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 2, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 15, 1930 to May 2, 1930

that I last saw him alive on May 15, 1930

and that death occurred on the date stated above, at 10 15 a.m.

The CAUSE OF DEATH * was as follows:

Carcinoma stomach

(Duration) 1 yrs. 0 mos. 0 ds.

Contributory Secondary Antacid

(Duration) 8 yrs. 0 mos. 0 ds.

(Signed) W. B. Haynes M. D.

May 2, 1930 (Address) Belts Spring Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 3 yrs. 2 mos. 14 ds. In the State md. yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence md.

19 PLACE OF BURIAL OR REMOVAL Arrorettsville Md DATE OF BURIAL May 5, 1930

20 UNDERTAKER W. W. Hyson Co ADDRESS 1300 N. St. N.W.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—occident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>			13941			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>nr Cedar Grove</u> (No. _____)			(113)			Registration Dist. No. <u>211</u>		
2 FULL NAME <u>John Wesley Legonning</u>			St. _____			Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>M.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>						
6 DATE OF BIRTH <u>Nov. 3</u> , 19 <u>30</u> (Month) (Day) (Year)								
7 AGE _____ If LESS than 1 day _____ hrs. _____ yrs. _____ mos. <u>2</u> ds. or _____ min.?								
8 OCCUPATION (a) Trade, profession or particular kind of work <u>None</u> (b) General nature of industry business, or establishment in which employed or (employer) _____								
9 BIRTHPLACE (State or country) <u>Ind.</u>								
10 NAME OF FATHER <u>John Monroe Legonning</u>								
11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>								
12 MAIDEN NAME OF MOTHER <u>Maebel Agnes Hattenis</u>								
13 BIRTHPLACE OF MOTHER (State or Country) <u>Ind.</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John M. Legonning</u> (Address) <u>T. D. Clarkesburg, Ind.</u>								
15 Filed <u>Nov. 6</u> , 19 <u>30</u> <u>della H. Beall</u> Deputy Registrar.								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>Nov. 5</u> , 19 <u>30</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov. 3</u> , 19 <u>30</u> to <u>Nov. 5</u> , 19 <u>30</u> , that I last saw him <u>alive</u> on <u>Nov. 5</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>8:30</u> a.m. The CAUSE OF DEATH * was as follows: <u>Unknown to me, probably Gastro-intestinal disturbance.</u> (Duration) _____ yrs. _____ mos. _____ ds.								
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.								
(Signed) <u>George M. Boyer</u> M. D. <u>Nov. 5</u> , 19 <u>30</u> (Address) <u>Damascus Ind.</u>								
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____								
19 PLACE OF BURIAL OR REMOVAL <u>Salem M. E. Cemetery Cedar Grove, Ind.</u>						DATE OF BURIAL <u>Nov. 6th</u> , 19 <u>30</u>		
20 UNDERTAKER <u>J. B. Beall, Inc.</u>						ADDRESS <u>Damascus Ind.</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonoeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, leuæmia*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

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MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Moultrie

Village or City Redland (No. _____)

2 FULL NAME Infant Trout

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Wht. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 17, 1930
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Henry Trout

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Buelah Meyer

13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Trout

(Address) Woods, Ind.

15 Filed June 17 1930 Proctor, Dore & Helm
Registrar

06856 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 17, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 17 1930 to June 17 1930
that I last saw him alive on June 17, 1930

and that death occurred on the date stated above, at Don't know m.
The CAUSE OF DEATH was as follows:

Stillborn

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Henry D. Barber
June 17 1930 (Address) Redland

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Redland DATE OF BURIAL June 18 1930

20 UNDERTAKER Henry Trout ADDRESS Woods, Ind.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1. # 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Retroer wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

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N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Forest Glen (No. _____)

2 FULL NAME

TRUNDLE, GAIL DAWSON

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH March 31, 1927
(Month) (Day) (Year)

7 AGE 3 yrs. 6 mos. 6 ds. or min.?
If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Washington, D.C.

10 NAME OF FATHER Trundle, Americus Darn

11 BIRTHPLACE OF FATHER (State or country) Coolsville, Md.

12 MAIDEN NAME OF MOTHER Wright, Lucy Eleanor

13 BIRTHPLACE OF MOTHER (State or country) Forest Glen, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Lula Trundle

(Address) Forest Glen, Md.

15 Filed Oct 7, 1930 J. E. Wadley, Jr.
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 6, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 6 1930 to Oct 6, 1930
that I last saw him alive on Sept, 1930

and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH * was as follows:

Accidental drowning

(Duration) _____ yrs. _____ mos. _____ ds.
Contributory
Secondary

(Signed) Blum Mitchell M. D.
Oct 6, 1930 (Address) Silver Spring, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR CREMATION DATE OF BURIAL

Bellville Cemetery Oct 8, 1930

20 UNDERTAKER John Wright ADDRESS 1357 10 St. NW
Washington, D.C.

Mono-casy Smith
Beaverhill Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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NOV 7 1930

BUREAU

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE CAREFULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

<p>1 PLACE OF DEATH County <u>Montgomery</u></p>		<p>STATE OF MARYLAND CERTIFICATE OF DEATH</p>	
<p>Village or City <u>Rockville</u> (No. <u>57</u>)</p>		<p>Registration Dist. No. <u>213</u></p>	
<p>2 FULL NAME <u>Elgar Laurie Ischiffely</u></p>			
<p>PERSONAL AND STATISTICAL PARTICULARS</p>			
<p>3 SEX <u>male</u></p>	<p>4 COLOR OR RACE <u>White</u></p>	<p>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widowed</u></p>	
<p>6 DATE OF BIRTH <u>Nov 5</u>, 18<u>43</u> (Month) (Day) (Year)</p>			
<p>7 AGE <u>87</u> yrs. <u>6</u> mos. <u>29</u> ds. or min. If LESS than 1 day hrs.</p>			
<p>8 OCCUPATION (a) Trade, profession or particular kind of work <u>Retired</u> (b) General nature of industry business, or establishment in which employed or (employer)</p>			
<p>9 BIRTHPLACE (State or country) <u>D. C.</u></p>			
<p>10 NAME OF FATHER <u>F. A. Ischiffely</u></p>			
<p>11 BIRTHPLACE OF FATHER (State or country) <u>D. C.</u></p>			
<p>12 MAIDEN NAME OF MOTHER <u>Elizabeth Berry</u></p>			
<p>13 BIRTHPLACE OF MOTHER (State or Country) <u>D. C.</u></p>			
<p>14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs R. C. L. Smith</u> (Address) <u>Rockville Md</u></p>			
<p>15 Filed <u>6/6</u> 19<u>30</u> <u>Mrs. W. S. Rice</u> Registrar</p>			
<p>MEDICAL CERTIFICATE OF DEATH</p>			
<p>16 DATE OF DEATH <u>June 3</u>, 19<u>30</u> (Month) (Day) (Year)</p>			
<p>17 I HEREBY CERTIFY, That I attended the deceased from <u>May 29</u>, 19<u>30</u> to <u>June 3</u>, 19<u>30</u> that I last saw him alive on <u>June 3</u>, 19<u>30</u>, and that death occurred on the date stated above, at <u>9:35 P. m.</u> The CAUSE OF DEATH * was as follows: <u>Broncho pneumonia</u></p>			
<p>(Duration) yrs. mos. <u>4</u> ds.</p>			
<p>Contributory Secondary <u>Diabetes Mellitus</u></p>			
<p>(Duration) yrs. mos. ds.</p>			
<p>(Signed) <u>G. V. Hartley</u> M. D.</p>			
<p><u>June 4</u>, 19<u>30</u> (Address) <u>Rockville</u></p>			
<p>*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.</p>			
<p>18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)</p>			
<p>At place of death yrs. mos. ds. In the State yrs. mos. ds.</p>			
<p>Where was disease contracted, if not at place of death?</p>			
<p>Former or usual residence</p>			
<p>19 PLACE OF BURIAL OR REMOVAL <u>Darnestown Md</u></p>		<p>DATE OF BURIAL <u>June 6</u>, 19<u>30</u></p>	
<p>20 UNDERTAKER <u>W. P. Humphrey Jr</u></p>		<p>ADDRESS <u>Rockville Md</u></p>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUL 7 1930

BUREAU

N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

Village or City Rockville (No. _____)

2 FULL NAME Mary Helen Tucker

12571

(100-a)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 2/3

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH ? ? 1890
(Month) (Day) (Year)

7 AGE 40 yrs. ? mos. ? ds. or ? min. If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Nurse
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Md

10 NAME OF FATHER Benj. B. Bray

11 BIRTHPLACE OF FATHER (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Thompson

13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Roger T. Bray

(Address) Rockville Md

15 Filed 10-27 1923 Mrs. H. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 25, 19230
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct 23 19230 to Oct 25, 19230
that I last saw him alive on Oct 25, 19230,

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH * was as follows:

Bacterial Pneumonia

Contributory Secondary (Duration) yrs. mos. 16 ds.
Cerebrum on back

(Signed) O. T. Hawk M. D.
19230 (Address) Rockville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Rockville Union Cem. DATE OF BURIAL Oct 27, 19230

20 UNDERTAKER W. R. Humphrey ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill, (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysbacteria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

NOV 5 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Maryland

Village or City Polomac (No. _____)

2 FULL NAME Donald Eugene Buckley

10558 STATE OF MARYLAND
CERTIFICATE OF DEATH

159-2

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 23 1930
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 3 da. If LESS than 1 day _____ hrs. or _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Norman Buckley

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sadie Louis

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Norman Buckley
(Address) Polomac Md

15 Filed 9-27 1930 Mrs. T. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 26 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 23 1930 to Sept 26 1930
that I last saw him alive on Sept 26 1930
and that death occurred on the date stated above, at 10:30 P. m.
The CAUSE OF DEATH * was as follows:
Pulmonary Emphysema
Oval

(Duration) _____ yrs. _____ mos. 3 da.
Contributory Secondary Asphyxiation

(Duration) _____ yrs. _____ mos. 1 da.
(Signed) Dr. R. H. ... M. D.
Sept 27 1930 (Address) 1664 Columbia

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL St. Mary's Cem-H. Rockville DATE OF BURIAL Sept 27 1930

20 UNDERTAKER W. R. Humphrey ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer—Retired 6 yrs.* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninginges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU V. S.

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

04483

(44)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 223Village or City Takoma Park

Washington Sanatorium death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Horner B Turrell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Dec 22 1868
(Month) (Day) (Year)

7 AGE 61 yrs. 4 mos. 17 ds. If LESS than 1 day... hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Violin Maker
(b) General nature of industry, business, or establishment in which employed or (employer) Dealer in Music

9 BIRTHPLACE (State or country) Indiana

10 NAME OF FATHER W. S. Turrell

11 BIRTHPLACE OF FATHER (State or country) Ohio

12 MAIDEN NAME OF MOTHER Elizabeth Carr

13 BIRTHPLACE OF MOTHER (State or Country) Indiana

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Maude B. Estel(Address) Washington Sanatorium

15 Filed April 9 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 9 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 18 1923 to April 9 1930, that I last saw him alive on April 7 1930, and that death occurred on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH * was as follows:

Large Intestinal Carcinoma
Primary in the stomach. Metastases.
(Duration) yrs. mos. da.

Contributory Intestinal Obstruction
Secondary (Duration) yrs. mos. da.

(Signed) D. T. Green M. D.
Apr 9 1930 (Address) Takoma Park D.C.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Medora Indiana

Former or usual residence Medora Indiana

19 PLACE OF BURIAL OR REMOVAL Medora, Ind. DATE OF BURIAL Apr. 10, 1930

20 UNDERTAKER H. B. Nevins ADDRESS 924 N. Y. Ave.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Puglistain, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Dysphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAY 3 1930

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N. B.—Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		03126		STATE OF MARYLAND	
County <u>Montgomery</u>		(125)		CERTIFICATE OF DEATH	
Village or City <u>Silver Spring</u>		No. <u>919 Sligo Avenue</u>		Registration Dist. No. <u>214</u>	
2 FULL NAME <u>William Eckleston Turtton</u>		St. _____		Ward _____	
<p>(If death occurred in a hospital or institution, give its NAME instead of street and number.)</p>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>February 19</u> , 18 <u>60</u> (Month) (Day) (Year)					
7 AGE <u>70</u> yrs. <u>—</u> mos. <u>19</u> ds. or <u>—</u> min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Builder (Retired)</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>House construction</u>					
9 BIRTHPLACE (State or country) <u>District of Columbia</u>					
10 NAME OF FATHER <u>George H. Turtton</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>District of Columbia</u>					
12 MAIDEN NAME OF MOTHER <u>Catherine Durand</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>District of Columbia</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. William E. Turtton</u> (Address) <u>Silver Spring, Md.</u>					
15 Filed <u>Mar. 10</u> 19 <u>30</u> <u>J. E. Winding</u> <u>Wiley</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>March 10</u> , 19 <u>30</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>on March 10</u> , 19 <u>30</u> to <u>—</u> , 19 <u>—</u> that I last saw him alive on <u>March 10</u> , 19 <u>30</u> and that death occurred on the date stated above, at <u>7:00 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Hemorrhage from lungs</u> <u>(Resulting from fall from</u> <u>roof of house)</u> <u>2 hours</u> (Duration) yrs. mos. ds.					
Contributory <u>Shock and Contusion</u> Secondary <u>from fall.</u> <u>2 hours</u> (Duration) yrs. mos. ds.					
(Signed) <u>W. H. Howlett</u> M. D. <u>March 10 1930</u> (Address) <u>928 Sligo Ave.</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, if not at place of death? <u>—</u> Former or usual residence <u>—</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Rock Creek Cemetery</u>				DATE OF BURIAL <u>3-12-1930</u>	
20 UNDERTAKER <u>Frank Geiers Sons Co.</u>				ADDRESS <u>1113-7</u> <u>Washington D.C.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Silver Spring (No. 901 Thayer Ave.

2 FULL NAME

Mary Jane Tyler

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH

January 3, 1860 (Month) (Day) (Year)

7 AGE

70 yrs. 10 mo. 24 ds. If LESS than 1 day... hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country) Maryland

10 NAME OF FATHER

John Gladman

11 BIRTHPLACE OF FATHER

(State or country) Maryland

12 MAIDEN NAME OF MOTHER

Catherine Maloy

13 BIRTHPLACE OF MOTHER

(State or Country) England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Mary V. Shaw

(Address)

901 Thayer Ave. Silver Spring, Md.

15

Filed Nov. 28, 1930

J. B. Dudley, Jr.
Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

November 27, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

November 20, 1930 to November 27, 1930

that I last saw her alive on November 27, 1930

and that death occurred on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage
(Right Hemiplegia)

(Duration) yrs. mos. 7 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) H. H. H. M. D.

Nov. 27, 1930 (Address) 928 Sligo Ave. Silver Spring, Md.

*State the Disease Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Hoodside Funeral Home

DATE OF BURIAL

Nov. 30, 1930

20 UNDERTAKER

Harner & Humphrey, Rockville

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

DEC 8 1930

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH
County Montgomery

08181

(90)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217Village or City Belney (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Silmar Van Zoosen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE N 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 8 - 20 - 1863
(Month) (Day) (Year)

7 AGE 65 yrs. 10 mos. 18 ds. or min. If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Gov. Clerk, Retiree
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Ind.

10 NAME OF FATHER Amold Van Zoosen

11 BIRTHPLACE OF FATHER (State or country) Ind.

12 MAIDEN NAME OF MOTHER Mary Harrington

13 BIRTHPLACE OF MOTHER (State or country) Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Van Zoosen(Address) Conestoga Rd

15 Filed July 8 1930 C. Barnsley
Registrar

for issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 - 8 - 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 7/27 1930 a. to 7/8 1930 a.

that I last saw him alive on 7/8 1930 a.

and that death occurred on the date stated above, at 6 a m.

The CAUSE OF DEATH * was as follows:

Chronic Myocarditis

(Duration) 2 yrs. ____ mos. ____ ds.

Contributory Acute debility
Secondary 7 heart

(Signed) J. B. Bird (Duration) ____ yrs. ____ mos. ____ ds. M. D.

7/8 1930 (Address) Sandy Sp. Ind.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Libertytown Md July 10 1930

20 UNDERTAKER W. W. Deal ADDRESS 816 - H St NE
Wash DC

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mastitis; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			09402 (90)		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgomery</u>			Village or City <u>Takoma Park</u> (No. <u>20</u> N. Y. Ave., St. <u>20</u> Ward)		Registration Dist. No. <u>223</u>	
2 FULL NAME <u>James Haver Van Hunter</u>						
PERSONAL AND STATISTICAL PARTICULARS						
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>				
6 DATE OF BIRTH <u>March 25</u> , 18 <u>57</u> (Month) (Day) (Year)						
7 AGE <u>73</u> yrs. <u>4</u> mos. <u>21</u> ds. or min.?						
8 OCCUPATION (a) Trade, profession or particular kind of work <u>govt. clerk</u> (b) General nature of industry business, or establishment in which employed or (employer) <u>—</u>						
9 BIRTHPLACE (State or country) <u>Indiana</u>						
10 NAME OF FATHER <u>John Peter Van Hunter</u>						
11 BIRTHPLACE OF FATHER (State or country) <u>Indiana</u>						
12 MAIDEN NAME OF MOTHER <u>Melissa James</u>						
13 BIRTHPLACE OF MOTHER (State or Country) <u>Kentucky</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. J. H. Van Hunter</u> (Address) <u>20 N. Y. Ave. Takoma Park, D.C.</u>						
15 Filed <u>Aug 18</u> 19 <u>30</u> <u>W. E. Rogers</u> Registrar						
MEDICAL CERTIFICATE OF DEATH						
16 DATE OF DEATH <u>Aug. 15</u> , 19 <u>30</u> (Month) (Day) (Year)						
17 I HEREBY CERTIFY, That I attended the deceased from <u>June 15</u> , 19 <u>30</u> to <u>Aug 15</u> , 19 <u>30</u> , that I last saw him alive on <u>Aug. 14</u> , 19 <u>30</u> , and that death occurred on the date stated above, at <u>1 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Chronic myocarditis</u>						
Indefinite (Duration) yrs. mos. ds.						
Contributory Secondary (Duration) yrs. mos. ds.						
(Signed) <u>W. E. Little</u> M. D. <u>Aug. 15</u> 19 <u>30</u> (Address) <u>6911 5th, Wash. D.C.</u>						
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.						
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence						
19 PLACE OF BURIAL OR REMOVAL <u>Washington, D.C.</u> DATE OF BURIAL <u>Aug. 18</u> , 19 <u>30</u>						
20 UNDERTAKER <u>The S. H. Hines Co.</u> ADDRESS <u>2901-14th St. N.W.</u>						

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus, *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

HOUTEN

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

MARGIN RESERVED FOR BINDING

WRITE INK WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Colesville, Md.

2 FULL NAME Sarah A. VanHorn

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH Sept. 24, 1848
(Month) (Day) (Year)

7 AGE 81 yrs. 4 mos. 26 ds. or min.?
If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country) Maryland

10 NAME OF FATHER Eliza Moore

11 BIRTHPLACE OF FATHER
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Harding

13 BIRTHPLACE OF MOTHER
(State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Alice Richardson

(Address) Silver Spring, R.F.D. # 1

15 Filed Feb 22 1930 C. S. Barnesley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 20, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb. 18, 1930 to Feb. 20, 1930
that I last saw her alive on Feb. 19, 1930

and that death occurred on the date stated above, at 12:45 a.m.
The CAUSE OF DEATH * was as follows:

Lobar Pneumonia

(Duration) 2 yrs. 2 mos. 2 ds.

Contributory
Secondary

Influenza

(Duration) 8 yrs. 8 mos. 8 ds.

(Signed) C. S. Barnesley M. D.

Feb 21 1930 (Address) Sandy Spring

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Colesville

2/22, 1930

20 UNDERTAKER

ADDRESS

W. E. Pumphrey

Rockville, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

for issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Scrofula, etc.*, of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 4 1930
BUREAU U. S.

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1 PLACE OF DEATH
County Montgomery

09403

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 212Village or City Poolesville (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Minerva Lane Veirs

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH April 10, 1884
(Month) (Day) (Year)

7 AGE 83 yrs. 4 mos. 26 ds. or LESS than 1 day _____ hrs. or _____ min.

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed or (employer) X

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Leslie Veirs

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia Veirs

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. B. And
(Address) Poolesville, Md.

15 Filed Aug 8 1930 E. White
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 6, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from no physician 1922, 1922, that I last saw him alive on Attended 1922.

and that death occurred on the date stated above, at 6 P m. The CAUSE OF DEATH * was as follows:

Organic heart disease

(Duration) 5 yrs. _____ mos. _____ ds.
Contributory Heart Exhaustion
Secondary

(Signed) E. W. White M. D.
Aug 8 1930 (Address) Poolesville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Bellaville DATE OF BURIAL Aug 8, 1930

20 UNDERTAKER Hilton Hall ADDRESS Poolesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchiopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchiopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely, symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Montgomery

Village or City Takoma Park No. Md Washington Sanitarium Hospital Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Miss Nannie Uiers

08515 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE American white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH February unknown, 1862
(Month) (Day) (Year)

7 AGE 68 yrs. 5 mos. 7 ds. or min.?
If LESS than 1 day... hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Bethesda, Maryland

10 NAME OF FATHER Samuel Clark Uiers

11 BIRTHPLACE OF FATHER (State or country) Rockville, Md.

12 MAIDEN NAME OF MOTHER Esther Uiers

13 BIRTHPLACE OF MOTHER (State or country) Dawsonville, Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington Sanitarium Records
(Address) Takoma Park, Md.

15 Filed July 25 1930 J. E. B. Underly
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 24, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 23, 1930 to July 24, 1930
that I last saw her alive on July 24, 1930
and that death occurred on the date stated above, at 12¹⁵ P. m.

The CAUSE OF DEATH was as follows:

Operation for gallstones
Cholecystectomy
(Duration) yrs. mos. 3 ds.

Contributory Secondary Heart failure
(Duration) yrs. mos. 1 ds.

(Signed) Julien H. Hays M. D.
2-24-1930 (Address) 1309 R. Fairview

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 16 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death? Rockville, Md.

Former or usual residence Rockville, Md. - R.F.D. #3

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Lion

7.26.1930

20 UNDERTAKER

ADDRESS

Warner & Humphrey Rockville, Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labor pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Malaria*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
SEP 6 1900
BUREAU

MARGIN RESERVED FOR BINDING

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montg.</u> Village or City <u>Rockville</u> (No. <u>90</u>)			STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>213</u>		
2 FULL NAME <u>William C. Veirs</u>			St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME, extend of street and number.)		
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	16 DATE OF DEATH <u>June 10, 1930</u> (Month) _____ (Day) _____ (Year) _____		
6 DATE OF BIRTH <u>May 23, 1855</u> (Month) _____ (Day) _____ (Year) _____			17 I HEREBY CERTIFY, That I attended the deceased from <u>Nov.</u> 1928 to <u>June 10, 1930</u>		
7 AGE <u>75</u> yrs. <u>0</u> mos. <u>27</u> ds. or _____ min.?			that I last saw him alive on <u>June 9, 1930</u>		
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed or (employer) _____			and that death occurred on the date stated above, at <u>545 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Myocarditis</u>		
9 BIRTHPLACE (State or country) <u>Maryland</u>			Contributory (Duration) <u>1</u> yrs. _____ mos. _____ ds. Secondary <u>Sateral sclerosis</u>		
PARENTS	10 NAME OF FATHER <u>Hezekiah Veirs</u>		(Duration) <u>2</u> yrs. _____ mos. _____ ds.		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		(Signed) <u>J. V. Hartley</u> M. D.		
	12 MAIDEN NAME OF MOTHER <u>Miss. Floyd</u>		<u>June 12, 1930</u> (Address) <u>Rockville</u>		
13 BIRTHPLACE OF MOTHER (State or Country) <u>Maryland</u>		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) <u>Mr. Eugene Veirs</u>					
(Address) <u>P. O. Box Rockville Md</u>					
15 Filed <u>6-18</u> 19 <u>30</u> <u>Wm H. T. Pratt</u> Registrar			19 PLACE OF BURIAL OR REMOVAL <u>St. Marys, Rockville Md</u>		
			DATE OF BURIAL <u>6/12</u> 19 <u>30</u>		
			20 UNDERTAKER <u>W. S. Humphrey</u>		
			ADDRESS <u>Rockville</u>		

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. S.

JUL 7 1900

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

IF LESS than
1 day ____ hrs.
or ____ min.?

8 OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed or (employer)9 BIRTHPLACE
(State or country)10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER
(State or country)12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

192

Registrar

13943

(74-2)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

Ward

(If death occurred in
a hospital or institu-
tion, give its NAME ; -
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Contributory
Secondary

(Duration) yrs. mos. da.

(Duration) 10 yrs. 0 mos. 0 da.

(Signed)

M. D.

1804 1930 (Address)

*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.19 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-
ients or Recent Residents)At place
of death. 1 yrs. 1 mos. 8 ds.In the
State. yrs. mos. da.Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (c) *Salesman*, (b) *Grocery*;

(a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Seizal, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the standard accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

BUREAU V. B.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Icteric," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Rarefied wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montg.

Village or City

Near. Poolesville

(No. _____)

2 FULL NAME

Annus E. Waddel

03127

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED

Single

6 DATE OF BIRTH

Aug 6 1912
(Month) (Day) (Year)

7 AGE

17 yrs. 7 mos. 5 ds. or min.?

If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Va.

10 NAME OF FATHER

Prince Waddel

11 BIRTHPLACE OF FATHER

(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Saddie Potten

13 BIRTHPLACE OF MOTHER

(State or Country)

Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Prince Waddell

(Address)

Sellman, Md

15 Filed

Mar 15 1930 E. W. White

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 13th, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Jan 1928 to March 12th, 1930
that I last saw her alive on March 12th, 1930

and that death occurred on the date stated above, at 1:50 A. M.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

(Duration) 3 yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Upton D. Nourse M. D.

3/14/30 192 (Address) S. Ansonville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.

In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Beallsville, Md

3/15, 1930

20 UNDERTAKER

ADDRESS

Halton & Hall

Poolesville

MK

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 4 1908
BUREAU V. S.

MARGIN RESERVED FOR BINDING
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Montgomery

Village or City Olney (No. _____)

² FULL NAME Mary Hader

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 217

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 4-8-1896
(Month) (Day) (Year)

7 AGE 38 yrs. 8 mos. 20 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) MD

10 NAME OF FATHER Gas. Adams

11 BIRTHPLACE OF FATHER (State or country) MD

12 MAIDEN NAME OF MOTHER Mary Beers

13 BIRTHPLACE OF MOTHER (State or country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) (1)

(Address) _____

15 Filed Jan 6 1930 mo C.S. Barnole Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1/2/1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 12/28/1929 to 1/2/1930, that I last saw him alive on 1/2/1930

and that death occurred on the date stated above, at 8 P m. The CAUSE OF DEATH * was as follows:

Cerebral Scur
(Duration) _____ yrs. _____ mos. 16 ds.

Contributory
Secondary

(Signed) J. M. Smith M. D.
1/3/1930 (Address) Sandy Spring

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Sandy Spring, Md Jan 7, 1930

20 UNDERTAKER ADDRESS

Geo R. Snodden Rockville Md

fee issued.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs.* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

BUREAU V. D.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

statement of **OCCUPATION** is very important. See instructions on back of certificate.

County Montgomery

Village or City Chevy Chase (No. 4607 Stunt Ave.

2FULL NAME Mary Savin Halbach

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 SINGLE, *widowed*
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6⁴ DATE OF BIRTH Sept 3, 1846
(Month) (Day) (Year)

7 AGE 83 If LESS than
84 yrs. 9 mos. 12 ds. | day... hrs.
or... min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE
(State or country) *Baltimore, Md.*

10 NAME OF FATHER *John Halbach*

11 BIRTHPLACE
OF FATHER
(State or country) *Balto, Md.*

12 MAIDEN NAME OF MOTHER P. E. Woods

13 BIRTHPLACE
OF MOTHER
(State or Country). *Baeto. Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Mary B. Walbach
(Address) 4607 Kent Ave.

15 Filed July 14 19230 Benj. C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14th, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended the deceased from July 1st 1930 to July 14th 1930 that I last saw her alive on July 13th 1930 and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH * was as follows:
Chronic arterio-sclerosis

Fracture was due to a fall, on steps c.m. 2. P.

(Duration) 2 yrs mos. ds

Contributory Secondary fracture of hip
(Duration) yr mo 14 da

(Signed) [Signature] M. D.
July 14 1920 (Address) Bethesda, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

1B LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or
usual residence.....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
-------------------------------	----------------

Friend Ridge Cemetery July 16, 1930
Baltimore, Md. ADDRESS

Y. R. Purnbren Jr. Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

AUG 5 1930

MARGIN RESERVED FOR BINDING
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg

15184

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218Village or City Gaithersburg (No.)

St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Crittenden M Walker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH Nov 19 1857
(Month) (Day) (Year)7 AGE 73 yrs. 1 mos. 3 ds. If LESS than 1 day ____ hrs. or ____ min.?8 OCCUPATION
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry, business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Md10 NAME OF FATHER Nathan J Walker11 BIRTHPLACE OF FATHER (State or country) Md12 MAIDEN NAME OF MOTHER Evanlin King13 BIRTHPLACE OF MOTHER (State or Country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs C M Walker(Address) Gaithersburg Md15 Filed Dec 23 1930 Paula Lane Ellison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12-22-1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 5-14-1930 to 12/22-1930
that I last saw him alive on 12/22-1930
and that death occurred on the date stated above, at 3:40 p.m.
The CAUSE OF DEATH * was as follows:Hypertrophy of the Heart
(Duration) 3 yrs. ____ mos. ____ ds.Contributory
Secondary Paralysis
(Duration) ____ yrs. 1 mos. 11 ds.(Signed) J. N. Simpers M. D.12/23 1930 (Address) Gaithersburg Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Gaithersburg MdDec 24 1930

20 UNDERTAKER

ADDRESS

E C GARTNERGaithersburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former Occupied 6 yrs.*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Cerebrum, Sorcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—occident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

JAN 6 1931

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City Takoma Park, Md. (No. Washington San. & Hosp. Ward 8)

2 FULL NAME

Rildred Wallace

06859

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

January 31, 1892
(Month) (Day) (Year)

7 AGE

38 yrs. 4 mos. 27 ds. or min.

If LESS than 1 day ____ hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Morehead City, N.C.

10 NAME OF FATHER

Chas. S. Wallace

11 BIRTHPLACE OF FATHER

(State or country)

Portsmouth, N.C.

12 MAIDEN NAME OF MOTHER

Nina Webb

13 BIRTHPLACE OF MOTHER

(State or Country)

Morehead City, N.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sanitarium Records

(Address)

Takoma Park, Md.

15

Filed June 28, 1930H. C. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

June 28, 19306 (Month) 28 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from May 19, 1930 to June 28, 1930that I last saw her alive on June 28, 1930and that death occurred on the date stated above, at 3:55 p.m.
The CAUSE OF DEATH * was as follows:Subacute Bacterial Endocarditis

Contributory Secondary

(Duration) 4 yrs. 4 mos. 4 ds.Cardiac failure

(Signed)

Chas. H. Hophorn M.D.192 (Address) Takoma Park, Md.

*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 1 mos. 9 ds.In the State 0 yrs. 1 mos. 9 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Morehead City, N.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington San. & Hosp.June 28, 1930

20 UNDERTAKER

ADDRESS

W. B. BrownWash. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg Co

Village or City Germantown (No. _____)

2 FULL NAME Annie Rebecca Wallack

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 218

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow

6 DATE OF BIRTH 1855 Nov 28th 1855
(Month) (Day) (Year)

7 AGE 76 yrs. 11 mos. 28 ds. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Henry Bennett

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Savilla Miller

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr John Wallack
(Address) Germantown Md

15 Filed Nov 20 1920 Beulah Lane Epling
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov - 18 - 19230
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended the deceased from June 21 1929 to Nov. 18 19230
that I last saw h. W alive on Nov - 17 19230

and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH * was as follows:

Chronic Myocarditis

(Duration) 2 yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

Nov 20 19230 (Address) Saithersburg

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Germantown DATE OF BURIAL Nov 20, 1930

20 UNDERTAKER E C Gartner ADDRESS Saithersburg Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Cerebrum, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

DEC 6 1930

BUREAU

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

09404
(122-2) STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Jakoma Park Md. Wash. San. & Hosp. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Theodore Walter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) MARRIED

6 DATE OF BIRTH May 13 1877
(Month) (Day) (Year)

7 AGE 53 yrs. 2 mos. 19 ds. or min. (If LESS than 1 day, hrs.)

8 OCCUPATION
(a) Trade, profession or particular kind of work Retired merchant
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Theodore Walter

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ruth Bickford

(Address) Wash. San. & Hosp. Jakoma Park.

15 Filed Aug 2 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug (Month) 2nd (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 30 1930 to Aug 2 1930, that I last saw him alive on Aug 2 1930, and that death occurred on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH * was as follows:

Hepatic & Biliary Cirrhosis

Contributory Secondary Chronic Alcoholism (Duration) yrs. mos. ds.

(Signed) J. H. Press M. D. Aug 2 1930 (Address) Jakoma Park D.C.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1332 Newlock St. N.W. Wash.

19 PLACE OF BURIAL OR REMOVAL Washington, D.C. DATE OF BURIAL 8/3 1930

20 UNDERTAKER Thos. F. Murray & Son ADDRESS 2007-Nichols Ave. S.E.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Coal engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"; *Typhoid fever* never report "Typhoid Pneumonia"; *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Maryland

Village or City Redland (No.)

2 FULL NAME Martha V. Ward

01835

(29)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 215

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Wh. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widow

6 DATE OF BIRTH Don't know
(Month) (Day) (Year)

7 AGE 73 about If LESS than 1 day hrs. min.?
yrs. mos. ds. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed or (employer) none

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sarah E. Chambers

13 BIRTHPLACE OF MOTHER (State or country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Amanda Thaler

(Address) Herndon, Md.

15 Filed Feb 19 1930 Paul D. E. Johnson
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 17 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 15 1930 to Feb 17 1930, that I last saw him alive on Jan 23 1930, and that death occurred on the date stated above, at 1 A m.

The CAUSE OF DEATH * was as follows:

Chronic myocarditis

Contributory
Secondary

Interstitial nephritis
(Duration) 2 yrs. mos. ds.

(Signed) Stanley W. Barber M. D.
Feb 19 1930 (Address) Baltimore, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 73 yrs. mos. ds. In the 73 State 73 yrs. mos. ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL Baltimore

DATE OF BURIAL Feb 20 1930

20 UNDERTAKER Reg. H. Barber

ADDRESS Leposville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Sprinter, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bro. chloepneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Ashenia," "Anæmia;" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Maryland

03128

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218Village or City New Election (No. _____)

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Georgetta Warfield

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
------------------------	---------------------------------	--

6 DATE OF BIRTH <u>Under one hundred</u> 1853 (Month) (Day) (Year)
--

7 AGE <u>76</u> yrs. _____ mos. _____ ds. or _____ min.?	IF LESS than 1 day _____ hrs.
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8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer).	<u>Home</u>
--	-------------

9 BIRTHPLACE (State or country)	<u>Maryland</u>
------------------------------------	-----------------

10 NAME OF FATHER	<u>Larkin Shipley</u>
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11 BIRTHPLACE OF FATHER (State or country)	<u>Maryland</u>
---	-----------------

12 MAIDEN NAME OF MOTHER	<u>Liza Beulow</u>
--------------------------	--------------------

13 BIRTHPLACE OF MOTHER (State or Country)	<u>Maryland</u>
---	-----------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. J. Warfield(Address) Chesapeake B. & O.15 Filed Mar 25 - 1930 W. T. Oyster Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 23, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept 5, 1929 to Mar 23, 1930.that I last saw her alive on Mar 23, 1930.and that death occurred on the date stated above, at 8:40 p.m.

The CAUSE OF DEATH * was as follows:

ArteriosclerosisContributory Secondary (Duration) 2 yrs. _____ mos. _____ ds.
Coronary Heart Disease

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. T. Oyster M. D.Mar 25, 1930 (Address) Laytonville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Wm Lebanon Mar 25, 1930

20 UNDERTAKER ADDRESS

Ray W Barber Laytonville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1930
BUREAU OF VITALS

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

15185

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

Village or City

Leptonville

St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Rachel V Warfield

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED, WIDOWED,
OR DIVORCED
(Write the word)

widowed

6 DATE OF BIRTH

85

August

13

1845

(Month)

(Day)

(Year)

7 AGE

85 yrs.

3

mos.

19

ds.

If LESS than
1 day.....hrs.
or.....min.?

8 OCCUPATION

a) Trade, profession or
particular kind of work

none

(b) General nature of industry
business, or establishment in
which employed or (employer)

none

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF
FATHER

W. T. Dorsey

11 BIRTHPLACE
OF FATHER

(State or country)

Maryland

12 MAIDEN NAME
OF MOTHER

May Childs

13 BIRTHPLACE
OF MOTHER

(State or Country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. T. Dorsey

(Address)

9 Faithersburg

15

Filed Dec 4

1930

V. T. Dorsey

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec

2

1930

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Jan 5 1928 to Dec 2 1930,

that I last saw her alive on Dec 2 1930,

and that death occurred on the date stated above, at 6 P. m.

The CAUSE OF DEATH * was as follows:

Chronic Mitral Insufficiency
of the Heart

(Duration) 3 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) W. T. Dorsey M. D.

Dec 4 1930 (Address) Leptonville Md

*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury and (2) Whether
Accidental, Suicidal or Homicidal.18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Trans-
ients or Recent Residents)At place
of death yrs. mos. ds.In the
State yrs. mos. ds.Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Goshen Cemetery

12/4

1930

20 UNDERTAKER

ADDRESS

Roy W. Barber Faithersburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architec, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, "PUERPERAL peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JAN 6 1931
BUREAU

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Rockville No. _____

2 FULL NAME Daniel Barnes

06860 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Feb 18, 1839
(Month) (Day) (Year)

7 AGE 91 yrs. 3 mos. 17 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Boatman
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) _____

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (State or Country) _____

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Nicholson
(Address) Rockville County Home

15 Filed 6-6-1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 5, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 3, 1930 to June 1, 1930

that I last saw him alive on June 1, 1930

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

Apoplexy

(Duration) ____ yrs. ____ mos. 4 ds.

Contributory Secondary Chronic Myocarditis

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. S. Hawke M. D.

192____ (Address) Rockville Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

County Cemetery 6, 6, 1930

20 UNDERTAKER ADDRESS

Harmon E. Dunphy Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUL 7 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

19

30

W L Linn

Registrar

(21)

03129

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME, address of street and number.)

MEDICAL CERTIFICATE OF DEATH

6 DATE OF DEATH

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I found the deceased from 192 to 192

that I last saw her alive on March 2, 1930

and that death occurred on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH * was as follows:

Tuberculosis of the lungs
(Duration) 2 yrs. 10 mos. 3 ds.
Contributory Secondary Tuberculosis of the lungs
(Duration) 3 yrs. 10 mos. 3 ds.
(Signed) M. D. [Signature]
March 3, 1930 (Address) [Signature]
[Signature]

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

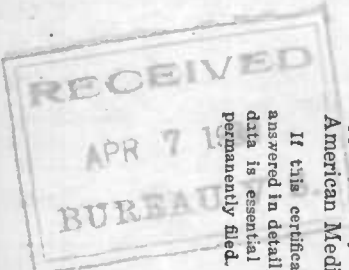
(Approved by U. S. Census and American Public
Health Association)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Meningitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Meningitis (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Emaciation," "Heart failure," "Hæmorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Kinross (No. _____) St. _____ Ward _____

2 FULL NAME Emma Harfield Warden

15187 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH June 23, 1863
(Month) (Day) (Year)

7 AGE 67 yrs. 6 mos. 22 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Wm H. Harfield

11 BIRTHPLACE OF FATHER (State or country) Penn.

12 MAIDEN NAME OF MOTHER Ann Miller

13 BIRTHPLACE OF MOTHER (State or Country) Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Carroll Durrell

(Address) Kinross Md

15 Filed Dec 16, 1930 W. L. Lewis
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec 16, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Dec 15, 1930 to Dec 16, 1930

that I last saw him alive on Mon Dec 15, 1930

and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH * was as follows:

Cerebral Hemorrhage

(Duration) 2 hrs yrs. ____ mos. ____ ds.

Contributory Secondary Arterio Sclerosis

(Signed) W. L. Lewis M. D.

12-16 1930 (Address) Kinross

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Damascus Dec. 18, 1930

20 UNDERTAKER ADDRESS

W. R. Pumphrey Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, Peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Renal wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JAN 5 1931

BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery06861 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213Village or City Potomac (No. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Stephory Washington

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.4 COLOR OR RACE Negro5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) SINGLE6 DATE OF BIRTH June 27, 1930
(Month) (Day) (Year)7 AGE 0 yrs. 0 mos. 0 ds. or 0 min.?

If LESS than 1 day 0 hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Ind10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (State or country) Ind12 MAIDEN NAME OF MOTHER Beatrice Washington13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ✓

(Address) _____

15 Filed 6/27 1930 Mrs. Pratt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 27, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192,
that I last saw him alive on _____, 192and that death occurred on the date stated above, at _____ m.
The CAUSE OF DEATH * was as follows:Still born

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. Hartley M. D.
6/27 1930 (Address) Richville

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Potomac, IndDATE OF BURIAL 6/27, 193020 UNDERTAKER Sorensen WashingtonADDRESS Potomac

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, Peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUL 7 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Rockville, Md. R.F.D. (near Agate)

2 FULL NAME

Bessie WashingtonSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Coloured5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)Single

6 DATE OF BIRTH

Unknown - 1 (Year)

7 AGE

41 (?) yrs. mos. ds. or min. If LESS than 1 day hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

none

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Montg. Co., Md.

10 NAME OF FATHER

Hilary Washington

11 BIRTHPLACE OF FATHER (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Kate Matthews

13 BIRTHPLACE OF MOTHER

(State or Country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thos. Thomas (brother)

(Address)

Rockville, Md.

15

Filed Nov 11, 1930 C. S. Barnsley Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Nov. 9, 1930 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Oct 28 1930 to Nov 9 1930.that I last saw her alive on Nov 9 1930,and that death occurred on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH * was as follows:

Myocarditis, with
decompensation & ascites.

(Duration) yrs. mos. ds.

Contributory
SecondaryObesity

(Duration) yrs. mos. ds.

(Signed) Wm. O. Lenthorn M. D.Nov. 11 1930 (Address) Rockville, Md.

*State the cause of death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sandy SpringNov 11, 1930

20 UNDERTAKER

ADDRESS

Geo. P. SnoudenRockville

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Pugstian, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Form laborer, Loberer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labour pneumonia*, *Bronchiopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchiopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—occident*; *Revolver wound of head—homicide*; *Poisoned by corbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 3 1930

BUREAU

R.

No lady named Rarr this
 morning. After she returned
 from a 12 months stay in a
 Washington D.C. Hosp. and
 suddenly after being home one
 wk. Physician refused to sign
 certificate as death occurred
 in Mary land.
 Rachel Rarr & Children
 Local Reg. 2/18

M.D.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>			03130 STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>318</u>		
Village or City <u>Emory Grove</u> (No. <u>1</u>)			St. <u>1</u> Ward <u>1</u> (If death occurred in a hospital or institution, give its NAME instead of street and number.)		
2 FULL NAME <u>Annice C. Waters</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>col.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>			
6 DATE OF BIRTH <u>July 13</u> , 1891 (Month) (Day) (Year)					
7 AGE <u>38</u> yrs. <u>7</u> mos. <u>20</u> ds. or min.?					
8 OCCUPATION (a) Trade, profession or particular kind of work <u>none</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>none</u>					
9 BIRTHPLACE (State or country) <u>Ind.</u>					
PARENTS	10 NAME OF FATHER <u>Jacob Neal</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>				
	12 MAIDEN NAME OF MOTHER <u>Archie Macatee</u>				
	13 BIRTHPLACE OF MOTHER (State or Country) <u>Ind.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Archie Neal</u> (Address) <u>Washington, Md.</u>					
15 Filed <u>Mar. 6</u> 192 <u>3</u> <u>Rachel Dore Echlin</u> Registrar					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>March 4</u> , 192 <u>3</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended the deceased from <u>10</u> to <u>10</u> , 192 <u>3</u> , that I last saw him alive on <u>10</u> , 192 <u>3</u> , and that death occurred on the date stated above, at <u>10</u> <u>10</u> m. The CAUSE OF DEATH * was as follows: <u>Arthritis</u> (Duration) <u>7</u> mos. <u>1</u> ds. Contributory <u>Removal of tonsils</u> Secondary (Duration) <u>2</u> mos. <u>1</u> ds. (Signed) <u>Rachel Dore Echlin</u> M. D. <u>Mar. 6, 1923</u> (Address) <u>Washington, D. C.</u>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.					
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u>Washington, D. C.</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Emory Grove</u>					DATE OF BURIAL <u>Mar. 6, 1923</u>
20 UNDERTAKER <u>Wm. H. Barker</u>					ADDRESS <u>Washington</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Soleman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masks; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Masks* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by running train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 5 1930
BUREAU V. S.

MARGIN RESERVED FOR BINDING

WRITE FULLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg

15186

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 34

Village or City Gaithersburg (No. 4)

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Maud Estelle Waters

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH

April 4th, 1869
(Month) (Day) (Year)

7 AGE

61 yrs. 8 mos. 24 ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Dr Joseph Getzendanner

11 BIRTHPLACE OF FATHER

(State or country) Md

12 MAIDEN NAME OF MOTHER

Mary Jane Sellman

13 BIRTHPLACE OF MOTHER

(State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) WM A Waters

(Address) Gaithersburg Md

15 Filed Dec 30 1930 Richard Darr Vicknam
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Dec. 28, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 1924 to Dec 28, 1930, that I last saw her alive on Dec 20, 1930.

and that death occurred on the date stated above, at 11:00 P.m.

The CAUSE OF DEATH * was as follows:

Cerebral hemorrhage

Contributory Secondary

(Duration) 1 min

(Duration) 6 yrs. mos. ds.

(Signed) J. J. Brooker M. D.

12 30 1930 (Address) Gaithersburg Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

19 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Beallsville Md
Monocacy Cemetary

DATE OF BURIAL

Dec 31, 1930

20 UNDERTAKER

ADDRESS

Ed. L. Gashner Gaithersburg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dog laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JAN 6 1931

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montg.

Village or City Rockville (No. _____)

2 FULL NAME Perrie E. Walters

15188
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2/3

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Sept 25, 1864
(Month) (Day) (Year)

7 AGE 63 yrs. 2 mos. 16 ds. or min.?
If LESS than 1 day... hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Register of Wills
(b) General nature of industry, business, or establishment in which employed or (employer) Montg Co Court House

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Horace Walters

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C. Johnson

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. P. E. Walters

(Address) Rockville Md.

15 Filed 12-12 1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH December 11, 1930
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended the deceased from Jan 20 1928 to Dec 11, 1930
that I last saw him alive on Dec 11, 1930

and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH * was as follows:

myocarditis Chronic

Contributory Secondary Chronic Nephritis
(Duration) 3 yrs. 0 mos. 0 ds.

Unknown (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) C. E. Hawks M. D.

12-11 1930 (Address) Rockville Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Rockville Cemetery DATE OF BURIAL Dec 13, 1930

20 UNDERTAKER Wm. Peyton Humphrey ADDRESS Rockville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered (officially, it will await further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City W. Lewisdale (No.)2 FULL NAME Morgan Hershey WatkinsSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 211

St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M.</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
--------------------	------------------------------	---

6 DATE OF BIRTH <u>Jan. 16</u> , 18 <u>72</u> (Month) (Day) (Year)
--

7 AGE <u>58</u> yrs. <u>11</u> mos. <u>8</u> ds. or min.?	If LESS than 1 day hrs.
--	------------------------------

8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)	<u>Farm labour</u>
---	--------------------

9 BIRTHPLACE (State or country)	<u>Ind.</u>
------------------------------------	-------------

10 NAME OF FATHER	<u>Lewis Watkins</u>
-------------------	----------------------

11 BIRTHPLACE OF FATHER (State or country)	<u>Ind.</u>
---	-------------

12 MAIDEN NAME OF MOTHER	<u>Amanda Watkins</u>
--------------------------	-----------------------

13 BIRTHPLACE OF MOTHER (State or country)	<u>Ind.</u>
---	-------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lewis Watkins(Address) P.O. Bluebury Ind.15 Filed Dec. 26 1930 Della O. Beall
Deft. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>Probably Dec. 23</u> , 19 <u>30</u> (Month) (Day) (Year)
--

17 I HEREBY CERTIFY, That I attended the deceased from <u>Dec. 24</u> 19 <u>30</u> to <u>Dec. 24</u> 19 <u>30</u>

that I last saw him alive on several months ago 192...and that death occurred on the date stated above, at Unknown Ind.

The CAUSE OF DEATH * was as follows:

Cold and exposure - Has been mired; lived alone and was found with but little clothes on today - Frozen.

(Duration) yrs. mos. ds.

Contributory Secondary

(Signed) <u>George M. Boyer</u> M. D.	(Duration) yrs. mos. ds.
<u>Dec. 25</u> 19 <u>30</u> (Address) <u>Damascus Ind.</u>	

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL <u>Bethesda Cemetery, W. Brownsville, Ind.</u>	DATE OF BURIAL <u>Dec. 26</u> , 19 <u>30</u>
---	---

20 UNDERTAKER <u>J. B. Beall, Inc. Damascus Ind.</u>	ADDRESS
---	---------

RECEIVED

JAN 5 1931

BUREAU V.S.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City in Damascus, Mo.2 FULL NAME William Edward Watkins

06862

(44)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 211

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OF RACE H. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)6 DATE OF BIRTH March 22 1855
(Month) (Day) (Year)7 AGE 75 yrs. 2 mos. 18 ds. or 1 day 1 hrs. 30 min.
If LESS than 1 day8 OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Silas Belt Watkins11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Sarah Ramsour13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Morgan Watkins(Address) R. D. Mt. Airy, Md.15 Filed June 13, 1930 Della O. Beall
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 10 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from May 1 1930 to June 10 1930, that I last saw him alive on June 9 1930, and that death occurred on the date stated above, at 11:30 a.m.
The CAUSE OF DEATH * was as follows:
Acute UræmiaContributory (Duration) 2 mos. 2 ds.
Secondary Carcinoma of liver + Gall-bladder (Duration) Unknown to me
(Signed) George M. Boyer M. D.
(Address) Damascus, Md.

*State the Cause Causing Death, or, in death from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Montgomery Chapel CemeteryDATE OF BURIAL June 13, 193020 UNDERTAKER L. B. Beall, Inc.ADDRESS Damascus, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* avoid use of "Croup"; *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary, or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITING ONLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated ACTUALLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County Montgomery

04484

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223Village or City Takoma Park (No. Washington Sanitarium St. Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME Eminetha Watson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>
------------------------	---------------------------------	---

6 DATE OF BIRTH
December 31, 1965
(Month) (Day) (Year)7 AGE
65 yrs. 4 mos. 11 ds. or min.?
If LESS than 1 day.....hrs.

OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed or (employer)

8 BIRTHPLACE (State or country) Sweden10 NAME OF FATHER Charles Gustafson11 BIRTHPLACE OF FATHER (State or country) Sweden12 MAIDEN NAME OF MOTHER Vesta Green13 BIRTHPLACE OF MOTHER (State or country) Sweden

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records

(Address)

15 Filed April 11 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
April 11, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from March 8, 1930 to April 11, 1930.that I last saw him alive on April 10, 1930.and that death occurred on the date stated above, at 1:35 A.M.

The CAUSE OF DEATH * was as follows:

Emphysema of the lungs
(Asymptomatic)
(Duration) 2 yrs. 0 mos. 0 ds.

Contributory
Secondary

(Signed) Donald E. Humphrey M. D.
4/11/30 1930 (Address) Takoma Park, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. 1 mos. 3 ds. In the State yrs. 1 mos. 3 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 6337 U. Street
Washington D.C.19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL 4/14, 193020 UNDERTAKER H. E. Rogers ADDRESS 1162 W. G.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by running train—neck; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A few data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAY 3 1930

BUREAU V

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Takoma Park Md. (No. 208 Maple Ave. St. 1, Ward 1)

03131
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 228

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Alice Weakley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH Sept 18, 1858
(Month) (Day) (Year)

7 AGE 71 yrs. 6 mos. 2 ds. or min. IF LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Pa.

10 NAME OF FATHER Nathaniel Martin

11 BIRTHPLACE OF FATHER (State or country) Pa.

12 MAIDEN NAME OF MOTHER Slingers.

13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nabel Proctor
(Address) Takoma Park Md.

15 Filed Mar 20 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH March 20, 1930
March (Month) 20 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from March 1 1929 to March 18 1930, that I last saw her alive on March 18, 1930.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Chronic Myo. Carditis

(Duration) 1 yrs. 0 mos. 0 ds.
Contributory Cardiac Failure
Secondary

(Signed) Edwin D. Lotthrop M. D.
March 20 1930 (Address) 705 E. Capt St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL March 20, 1930.

20 UNDERTAKER Clyde J. Nichols ADDRESS 4209 9th St N.W.
Washington, D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Fireman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Former (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc.; *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *A accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 2 1930

RECEIVED

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Silver Spring (No. 717 Sligo Avenue)2 FULL NAME Ray Alfred Weakley05725 STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single6 DATE OF BIRTH July 12th 1929
(Month) (Day) (Year)7 AGE 9 yrs. 20 mos. 20 ds. If LESS than 1 day hrs. or min.?8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer) —9 BIRTHPLACE (State or country) Maryland10 NAME OF FATHER Ellis Leonard Weakley11 BIRTHPLACE OF FATHER (State or country) Virginia12 MAIDEN NAME OF MOTHER Ethel Blanche Taylor13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Ellis S. Weakley(Address) Silver Spring, Md.15 Filed May 3 1930 J. E. Wadley Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 2nd 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from April 25 1930 to May 2 1930
that I last saw him alive on May 2 1930
and that death occurred on the date stated above, at 900 a.m.
The CAUSE OF DEATH * was as follows:Whooping CoughContributory Secondary (Duration) 2 yrs. 1 mos. 1 ds.
General Aesthenia(Signed) H. H. Howlett M. D.
May 2 1930 (Address) 928 Sligo Ave. Silver SpringState the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal. Whooping Cough

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.Where was disease contracted, if not at place of death? —Former or usual residence —19 PLACE OF BURIAL OR REMOVAL Stanley Va. DATE OF BURIAL 5, 3, 193020 UNDERTAKER Harold C. Crampton ADDRESS Laurelville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer. Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs.* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Menses; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Menses* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

JUN 7 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Rockville (No. _____)

2 FULL NAME Infant Hiddle

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH June 6, 1930
(Month) (Day) (Year)

7 AGE Stillborn If LESS than 1 day ____ hrs. ____ ds. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Rockville Md.

10 NAME OF FATHER Daniel R. Hiddle

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Elsie Matheny

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elsie M. Hiddle
(Address) Rockville, Md.

15 Filed 6-9 1930 Mrs. W. T. Pratt
Registrar

06863

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 6, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 6, 1930 to June 6, 1930
that I last saw him alive on June 6, 1930

and that death occurred on the date stated above, at 10 P. m.
The CAUSE OF DEATH * was as follows:

Abortion at 4 months
(Macerated foetus)

(Duration) ____ yrs. ____ mos. ____ ds.
Contributory Unknown
Secondary _____

(Signed) W. A. Lenthien M. D.
June 7, 1930 (Address) Rockville, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia");

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Ecthausion," "Heart failure," "Hæmorrhage," "Hæmion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUL 7 1930

MARGIN RESERVED FOR BINDING
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			6593 STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgomery</u>			Registration Dist. No. <u>217</u>	
Village or City <u>Norfolk</u> (No. _____)			St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Rhoda Annie Welsh</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>F</u>	4 COLOR OR RACE <u>W.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>unknown</u> , 18 <u>80</u> (Month) (Day) (Year)				
7 AGE <u>50</u> yrs. <u>unknown</u> mos. <u>unknown</u> ds. or <u>unknown</u> min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
PARENTS	10 NAME OF FATHER <u>Jacob Ross</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>			
	12 MAIDEN NAME OF MOTHER <u>Miss Dodson</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. Sam Welsh</u> (Address) <u>Norfolk, Va</u>				
15 Filed <u>Feb 2</u> 192 <u>9</u> <u>C. S. Barnsley</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>1/30/</u> , 19 <u>30</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>192</u> to <u>192</u> , that I last saw him alive on <u>192</u> , and that death occurred on the date stated above, at <u>1230 P. m.</u> The CAUSE OF DEATH * was as follows: <u>This patient was dead when I arrived. From history I would say Chronic Myocarditis</u> (Duration) yrs. mos. ds. Contributory <u>Acute Mitral Stenosis of Heart</u> Secondary (Duration) yrs. mos. ds. (Signed) <u>J. M. B.</u> M. D. <u>1930</u> (Address) <u>Sandy Spring</u> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>St. Mary, Rockville</u>			DATE OF BURIAL <u>2-3, 1930</u>	
20 UNDERTAKER <u>W. R. Pauphrey Jr. Rockville</u>			ADDRESS <u>Md.</u>	

for issued

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal parturitionis, etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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FEB 5 1930
BUREAU V 3

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Montgomery</u>			04485			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Germantown</u> (No. <u>2</u>)			St. <u>2</u> Ward <u>11</u>			Registration Dist. No. <u>211</u>		
2 FULL NAME <u>Unnamed Still Born Infant</u>								
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>M</u>		4 COLOR OR RACE <u>W</u>		5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>—</u>				
6 DATE OF BIRTH <u>4</u> / <u>18</u> / <u>1930</u> (Month) (Day) (Year)								
7 AGE <u>0</u> yrs. <u>0</u> mos. <u>0</u> da. or <u>0</u> min. ? If LESS than 1 day. <u>0</u> hrs.								
8 OCCUPATION (a) Trade, profession or particular kind of work <u>—</u> (b) General nature of industry, business, or establishment in which employed or (employer) <u>—</u>								
9 BIRTHPLACE (State or country) <u>Montg Co. Md.</u>								
PARENTS	10 NAME OF FATHER <u>George L. Wenzel</u>							
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>							
	12 MAIDEN NAME OF MOTHER <u>Gertrude Byron</u>							
13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>George Wenzel</u> (Address) <u>Germantown Md</u>								
15 Filed <u>Apr 18</u> 1923 <u>W. E. L. L. L. L.</u> Registrar								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>4</u> / <u>18</u> / <u>1930</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended the deceased from <u>at birth Stillborn</u> <u>4/18, 1930</u> that I last saw him <u>alive</u> <u>2 1/2 p.m.</u> and that death occurred on the date stated above, at <u>2 1/2 p.m.</u> The CAUSE OF DEATH <u>was as follows</u> <u>Prolapsed Fetus in part</u> <u>through birth canal</u> <u>Cephaloskeleton</u> (Duration) <u>8</u> yrs. <u>0</u> mos. <u>0</u> da.								
Contributory Secondary (Signed) <u>W. E. L. L. L.</u> M. D. <u>4/18/30</u> (Address) <u>Douglasville Md.</u>								
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.								
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> da. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> da. Where was disease contracted, if not at place of death? <u>—</u> Former or usual residence <u>—</u>								
19 PLACE OF BURIAL OR REMOVAL <u>Premises of Parents</u>						DATE OF BURIAL <u>4/19</u> 1930		
20 UNDERTAKER <u>Parent (Wenzel)</u>						ADDRESS <u>Germantown Md</u>		

RECEIVED

MAY 6 1930

BUREAU V. S.

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1 PLACE OF DEATH
County Montgomery

Village or City Seneca (No. _____)

2 FULL NAME Mary E. West

13946
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH 12 6 1899
(Month) (Day) (Year)

7 AGE 80 yrs. 11 mos. 9 ds. or min.?
IF LESS than 1 day hrs. min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed or (employer) Housekeeping

9 BIRTHPLACE (State or country) Montg Co Md.

10 NAME OF FATHER James Campbell
11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anne Beckwith

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry West
(Address) R 4 # 2 Germantown Md

15 Filed Mr 17/30 1930 Wm D. Russell M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 11 - 15 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 1921 to Nov. 15 1930

that I last saw her alive on Nov. 10 1930

and that death occurred on the date stated above, at 6:30 m.

The CAUSE OF DEATH * was as follows:

Myocardial Degeneration

Contributory Secondary (Duration) yrs. mos. ds. Coronary Atherosclerosis

(Signed) Wm D. Russell M. D.
Mr 17/30 1930 (Address) Sawonville MA

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Mary's Rockville DATE OF BURIAL Mr 17 1930

20 UNDERTAKER Ruben Kunkley ADDRESS Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death, 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DEC 5 1930
BUREAU

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1 PLACE OF DEATH

County

Montgomery

Village or City

Silver Spring

2 FULL NAME

Rosie West

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

col

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

unknown, 1901

7 AGE

29 yrs. unknown mos. ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

domestic

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

D C

10 NAME OF FATHER

Wm Grayson

11 BIRTHPLACE OF FATHER

(State or country)

Wm

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER

(State or country)

unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Agnes Duquesne

(Address)

Silver Spring

15

Filed Jan - 7

1930

J. E. Winderly

Registrar

STATE OF MARYLAND
6594 CERTIFICATE OF DEATH

Registration Dist. No.

214

St.: Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 7, 1930

17 I HEREBY CERTIFY, That I attended the deceased from

Found dead in bed

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Chronic Pulmonary Tuberculosis

Contributory Secondary

(Duration) yrs. 6 mos. ds.

(Signed) O. S. Hawks M. D.

1/7 1930 Address) Rockville Md

*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mark W. Jan 10 1930

20 UNDERTAKER

ADDRESS

Berneet Jones 2222 Gaard

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

New. D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and a few questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 7 1930
BUREAU V. S.

WRITE PLAINLY WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Takoma Park (No. Washington Sanitarium and Ward)2 FULL NAME Miss Sue WheatSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 223

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH January 24, 1862
(Month) (Day) (Year)7 AGE 68 yrs. 9 mos. 10 ds.
If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Virginia10 NAME OF FATHER Robert W. Wheat11 BIRTHPLACE OF FATHER (State or country) Virginia12 MAIDEN NAME OF MOTHER Susan Harper13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harriet Walter(Address) Washington Sanitarium15 Filed Oct 4, 1930 H. E. Rogers Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 4, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from Sept 25, 1930 to Oct 4, 1930, that I last saw her alive on Oct 4, 1930.and that death occurred on the date stated above, at 11:27 a.m.

The CAUSE OF DEATH * was as follows:

Periculous Pneumonia

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) D. H. Hens M. D. Oct 4, 1930 (Address) Takoma Park, D.C.

*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death At homeFormer or usual residence Gray Gables Co.19 PLACE OF BURIAL OR REMOVAL Alexandria, Va.DATE OF BURIAL Oct 4, 193020 UNDERTAKER John S. ArnoldADDRESS Alexandria, Va.

Wilcox
503 Julia.

Health Association.)

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Labour pneumonia*, *Bronchopneumonia* ("Pneumonia,"

RECEIVED
NOV 4 1939
BUREAU

If this certifi-
cated answered in de-
data to essential
permanently filed

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A thorough data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Montgomery</u>			Registration Dist. No. <u>216</u>	
Village or City <u>Glen Echo</u> (No. _____)			St. _____	Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2 FULL NAME <u>Infant of Irving & Blanche Wheeler</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>June 27, 1930</u> (Month) (Day) (Year)				
7 AGE _____ If LESS than 1 day _____ hrs. _____ yrs. _____ mos. <u>1</u> ds. or _____ min.?				
8 OCCUPATION (a) Trade, profession or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed or (employer) _____				
9 BIRTHPLACE (State or country) <u>N.D.</u>				
PARENTS	10 NAME OF FATHER <u>Irving Wheeler</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>			
	12 MAIDEN NAME OF MOTHER <u>Blanche Lane</u>			
	13 BIRTHPLACE OF MOTHER (State or Country) <u>D.C.</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE				
(Informant) <u>Irving Wheeler</u> (Address) <u>Glen Echo, Md.</u>				
15 Filed <u>June 28 1930</u> <u>Benj. C. Perry</u> Registrar				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>June 28, 1930</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended the deceased from <u>June 27, 1930</u> to <u>June 28, 1930</u> that I last saw him alive on <u>June 27, 1930</u> and that death occurred on the date stated above, at <u>11 a.</u> m. The CAUSE OF DEATH * was as follows: <u>Achilles tendon</u> <u>(Congenital)</u> (Duration) _____ yrs. _____ mos. <u>1</u> ds.				
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.				
(Signed) <u>Benj. C. Perry</u> M. D. <u>June 28 1930</u> (Address) <u>Bethesda, Md.</u>				
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.				
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Concord Church</u>				DATE OF BURIAL <u>June 28, 1930</u>
20 UNDERTAKER <u>Clarence Lane</u>				ADDRESS <u>Bethesda, Md.</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Soleman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Corioma, Sorcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

04486

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 214Village or City Fairland (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Willie Tyson Wheeler

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>W</u>	5 SINGLE, MARRIED, <u>Widowed</u> , WIDOWED, OR DIVORCED (Write the word)
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6 DATE OF BIRTH <u>March 11, 1855</u> (Month) (Day) (Year)
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7 AGE <u>75</u> yrs. <u>1</u> mos. <u>16</u> ds. or min.?	IF LESS than 1 day ____ hrs. 1 day ____ hrs.
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8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry business, or establishment in which employed or (employer)	<u>Farmer</u>
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9 BIRTHPLACE
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(State or Country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed April 28, 1930 J. E. W. W. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH <u>April 27, 1930</u> (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 20, 1930 to April 27, 1930 that I last saw him alive on April 27, 1930 and that death occurred on the date stated above, at 3 P. M. The CAUSE OF DEATH * was as follows:

Cerebral Thrombosis
while attempting to get out of bed, he fell, striking his head on edge of door.
(Duration) ____ yrs. ____ mos. 1 ds.
Contributory
Secondary lacerated forehead
of forehead (evident)
(Duration) ____ yrs. ____ mos. 1 ds.
(Signed) J. B. Haynes M. D.

April 28, 1930 (Address) Silver Spring, Md.
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds.	In the State ____ yrs. ____ mos. ____ ds.
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Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

<u>Coleville, Md.</u>	<u>April 28, 1930</u>
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20 UNDERTAKER

ADDRESS

<u>Lloyd Kainer</u>	<u>Lanesh, Md.</u>
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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Wm Bm

Village or City Kensington (No. _____)

2 FULL NAME Cornelius A Whitboeck

0595

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. _____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
6 DATE OF BIRTH Aug 8, 1840
7 AGE 89 yrs. 5 mos. 17 ds. or _____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) N.Y.

10 NAME OF FATHER Andrew Whitboeck

11 BIRTHPLACE OF FATHER (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Anna-

13 BIRTHPLACE OF MOTHER (State or Country) N.Y.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Edgar Smith
(Address) Kensington

15 Filed 1-25 1930 W L Sims
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 25, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 20 1930 to Jan 25 1930
that I last saw him alive on Jan 25 1930

and that death occurred on the date stated above, at 1:30 P m.
The CAUSE OF DEATH * was as follows:

Acute Myocarditis

(Duration) 1 yrs. 2 mos. 2 ds.
Contributory Secondary Grip

(Signed) W L Sims M. D.
1-25 1930 (Address) Kensington

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Roxville DATE OF BURIAL Jan 26, 1930

20 UNDERTAKER Walter E. Humphrey ADDRESS Roxville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "E. haustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, "Puerperal peritonitis," etc.* State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

FEB 7 1930
BUREAU V. S.

MARGIN RESERVED FOR BINDER
WRITE MAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Cabin John (No. _____)2 FULL NAME Theodora White

12573

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____6 DATE OF BIRTH July 2, 1930
(Month) (Day) (Year)7 AGE _____ If LESS than 1 day _____ hrs. _____ yrs. 3 mos. 22 ds. or min.?8 OCCUPATION
(a) Trade, profession or particular kind of work _____
(b) General nature of industry business, or establishment in which employed or (employer) _____9 BIRTHPLACE (State or country) Md. 10 NAME OF FATHER Rodney White11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Crofford13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rodney White
(Address) Cabin John Md15 Filed Oct 25 1930 Bey C. Perry
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 24, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from _____ 192 to _____ 192that I last saw h _____ alive on _____, 192

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

Malnutrition
Gastroenteritis: 2 weeks. Cough

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Bey C. Perry M. D.
Oct 24 1930 (Address) Bethesda Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Moses Lodge DATE OF BURIAL Oct 25 1930

20 UNDERTAKER

Rodney White ADDRESS Cabin John

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ashtenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 8 1930

BUREAU

RECEIVED

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

2 FULL NAME

10559

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day hrs.
or min.?

OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE

(>state or country)

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER

(State or country)

12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

Sept. 1 1930

J. E. Wadley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH * was as follows:

Acute dilatation of heart

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) M. D.

Sept. 12 1930 (Address) 8512 Ches. Ave.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death / yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If relieved from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

OCT 7 1930

BUREAU OF

unqualified, is indefinite; *Tuberculosis of lungs, meningitis, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mucosae; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mucosae* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptoms), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia, Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by passing train—accident; Revolver wound of head—homicide; Poisoned by cantharide acid—probably suicide*. The nature of the injury, *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH
County Montgomery

Village or City Wash Rockville

² FULL NAME Ellen Louise Williams

08180

STATE OF MARYLAND
CERTIFICATE OF DEATH

(113)

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH January 28 1930
(Month) (Day) (Year)

7 AGE 5 yrs. 22 mos. 22 ds. or min.?
If LESS than 1 day ____ hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed or (employer) _____

9 BIRTHPLACE (State or country) Montg. Co., Md.

10 NAME OF FATHER - Illegitimate

11 BIRTHPLACE OF FATHER (State or country) Unknown

12 MAIDEN NAME OF MOTHER Estelle Williams

13 BIRTHPLACE OF MOTHER (State or Country) Montg. Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Estelle Williams
(Address) Rockville, Md.

15 Filed 7/21 1930 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 20 1930 to July 20 1930, that I last saw her alive on July 20 1930, and that death occurred on the date stated above, at 10 P. m.

THE CAUSE OF DEATH * was as follows:
Enteritis with diarrhea
Probably dysentery
(Duration) ____ yrs. ____ mos. 10 ds.

Contributory none
Secondary _____
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Wm A. Antkowiak M. D.
July 21 1930 (Address) Rockville, Md.

*State the 1 is ase Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Norfolk DATE OF BURIAL 7.21, 1930

20 UNDERTAKER Harold Dunphy ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Archited, Locomotive engineer, Civil engineer, Stationary freman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mesles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Mesles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Propy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Œræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR INDEXING
WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Montgomery

Village or City

Glen

(No.)

2 FULL NAME

Janet Williams

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

213

St.: Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Wepo

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Nov 18th 1930

(Month)

(Day)

(Year)

7 AGE

0 yrs. 0 mos. 23 ds.

If LESS than

1 day hrs.

or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry business, or establishment in which employed or (employer)

"

9 BIRTHPLACE

(State or country)

D.C.

10 NAME OF FATHER

George Williams

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Ladies Russell

13 BIRTHPLACE OF MOTHER

(State or Country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ladies Williams

(Address)

Rockville Md RI

15 Filed

12/11

192

Miss W. T. Pratt

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Dec 11- 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Dec 11- 1930 to 1930

that I last saw him alive on 1930

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Atelectasis Pulmonum

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) M. J. Pratt M. D.

12/11 1930 (Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Emory Grove. Md 12/12 1930

20 UNDERTAKER

ADDRESS

George Williams Rockville Md RI

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

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Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds; Bronchopneumonia (secondary), 10 ds*. Never report mere symptoms or terminal conditions, such as "Ashenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JAN 6 1931

BUREAU

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

Village or City Bethesda (No. River Road St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Edith Lucretia Willett

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widowed

6 DATE OF BIRTH Feb. 8th 1845
(Month) (Day) (Year)

7 AGE 84 yrs. 11 mos. 24 ds. or min. If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Wash. D.C.

10 NAME OF FATHER John Thomas Deau

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Rachel Shoemaker

13 BIRTHPLACE OF MOTHER (State or country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mathia Fehmewald

(Address) Bethesda, Md.

15 Filed 2-4-30 Thomas K. Conrad Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb. 3rd 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Jan 21st 1930 to Feb 3 1930, that I last saw him alive on Feb. 2 1930.

and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH was as follows:

Pneumonia - Lobar

(Duration) yrs. 12 mo. da.

Contributory
Secondary

myocarditis

(Duration) 3 yrs. mo. da.

(Signed) Thomas K. Conrad M.P.
2-3-1930 (Address) Cherry Chase, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For hospitals, institutions, Transients or Recent Residents)

At place of death 85 yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death? at place of death

Former or usual residence above

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shoemaker Lom

2/5/30

20 UNDERTAKER

ADDRESS

Dr. H. Wise C.

2900-M. Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housewife*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

MAR 4 1930

BUREAU

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

03132

(44)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *223*Village or City *Lakoma Park* (No. *Washington Sanitarium*)

Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Henry Eugene Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

*white*5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
married

6 DATE OF BIRTH

April 3, 1845
(Month) (Day) (Year)

7 AGE

84 yrs. 11 mos. 25 ds. or min.?

If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed or (employer)

meteorologist

9 BIRTHPLACE

(State or country)

Connecticut

10 NAME OF FATHER

Ira Williams

11 BIRTHPLACE OF FATHER

(State or country)

Connecticut

12 MAIDEN NAME OF MOTHER

Almira Love

13 BIRTHPLACE OF MOTHER

(State or country)

Connecticut

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Hospital Records

(Address)

15 Filed

Mar 28

192

*30**H. E. Rogers*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 28, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Feb 17, 1930 to *Mar. 28, 1930*that I last saw him alive on *Mar 27, 1930*and that death occurred on the date stated above, at *12:40 A.M.*

The CAUSE OF DEATH * was as follows:

Causes of Stomach

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

D. H. Lee M. D.*Mar 28, 1930* (Address) *Lakoma Park, D.C.*

*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? *Contributory*Former or usual residence *Washington, D.C.*

19 PLACE OF BURIAL OR REMOVAL

Wash D.C.

DATE OF BURIAL

3-28, 1930

20 UNDERTAKER

John Reel Sons

ADDRESS

332-Pa. Ave. N.W.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

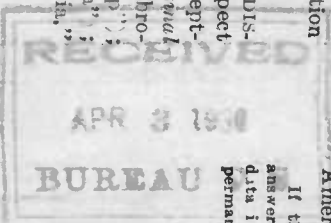
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "labore"; "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"; *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A the data is essential and must be obtained before the certificate is permanently filed.



N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. REGISTRARS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

2 FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

05-726

Registration Dist. No.

214

St. Ward)

If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

married

6 DATE OF BIRTH

7 AGE

If LESS than
1 day....hrs.

8 OCCUPATION

(a) Trade, profession or
particular kind of work(b) General nature of industry
business, or establishment in
which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF
FATHER

PARENTS

11 BIRTHPLACE
OF FATHER

(State or country)

12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

May 13, 1930

J. E. Wenderly

Registrar

If more blanks are needed, address State Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 12, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

May 8, 1930, to May 12, 1930,

that I last saw him alive on May 11, 1930,

and that death occurred on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH was as follows:

Pneumonia, Lobular

Contributory
SecondaryChronic Lobular Heart Disease
(Atherosclerosis and mitral regurgitation)

(Signed)

W. W. Mitchell

M. D.

192. (Address)

*State the Disease Causing Death, or, in deaths from
Violent Causes, state (1) Means of Injury; and (2) whether
Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place
of death....yrs....mos....da.In the
State....yrs....mos....da.Where was disease contracted,
if not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wash. D.C.

May 15, 1930

26 UNDERTAKER

ADDRESS

Thos. Frazier 389 R. 20

16 W. Saratoga St., Balto., Requestor V. S. No. 1

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine* etc. Women at home, who are engaged in the duties of the household, only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (retired 6 yrs.). For persons who have no occupation whatever, write *None*.

Succedent of Cause of Death—Name, first, the disease causing death (the primary affection), then the residue to time and causation, using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDER
WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County MontgomeryVillage or City Alney (No. Mont. Co. Hosp)2 FULL NAME Noah O. Wilson Mont Co 3rd Hosp06865
STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 211

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married6 DATE OF BIRTH July 24, 1863
(Month) (Day) (Year)7 AGE 67 yrs. 10 mos. 30 ds. or min. If LESS than 1 day hrs.8 OCCUPATION
(a) Trade, profession or particular kind of work Mechanic
(b) General nature of industry business, or establishment in which employed or (employer)9 BIRTHPLACE (State or country) West Virginia10 NAME OF FATHER Charles Nelson11 BIRTHPLACE OF FATHER (State or country) West Va.12 MAIDEN NAME OF MOTHER Matilda Asmuth13 BIRTHPLACE OF MOTHER (State or country) West Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William S. Wilson(Address) Rockville Md15 Filed June 24 1930 C. S. Barnsley
Registrarfor issue d.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 6/23/, 1930
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 6/1/ 1930 to 6/23/ 1930that I last saw him alive on 6/22/ 1930and that death occurred on the date stated above, at 5a m.
The CAUSE OF DEATH * was as follows:Chronic Interstitial Nephritis(Duration) 1 yrs. 0 mos. 0 ds.Contributory
SecondaryUremia(Duration) 5 yrs. 0 mos. 0 ds.(Signed) Jessie M. D.
6/23/1930 Address Bundy St 7 Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 0 mos. 0 ds. In the State 1 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death

Former or usual residence Wilson W. Va

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Rockville W Va June 26, 1930

20 UNDERTAKER ADDRESS

Roy W Barber LeithersburgIf more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1. mg

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary, may be entered as *Housewife, Housework*, or *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tubercia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUL 3 1930

BUREAU

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1 PLACE OF DEATH Montgomery
County Boyd

15191
②

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 211

Village or City Boyd (No. still Birth) St. Wilt Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME still Birth

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ♀ 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH 12-7-1930
(Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 0 ds. or min. If LESS than 1 day hrs.

8 OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (state or country) Boyd, Ind.

10 NAME OF FATHER Wm. Brown Wild

11 BIRTHPLACE OF FATHER (State or country) Fayetteville, Va.

12 MAIDEN NAME OF MOTHER Emma F. Newton

13 BIRTHPLACE OF MOTHER (State or country) Luckette, Va.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma F. Wild
(Address) Boyd, Ind.

15 Filed Dec 9th 1930 Wm. E. Lowe Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12-7-1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 12-7-1930 to 12-7-1930, that I last saw the deceased alive on 12-7-1930

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH * was as follows:

Still Birth
2 1/2 - 3 mos. fetus
(Duration) yrs. mos. ds.

Contributory
Secondary

(Signed) W. C. Miller M. D.
12-9-1930 (Address) Guthrieburg, Ind.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL at home DATE OF BURIAL 12-9-1930

20 UNDERTAKER ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

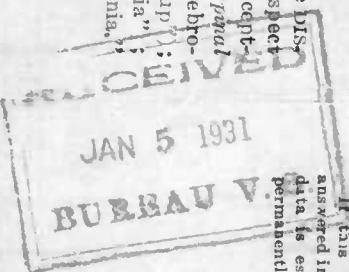
(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement, never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia", *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning, Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. A like data is essential and must be obtained before the certificate is permanently filed.



N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County MontgomeryVillage or City Laytonsville, Md (No. 101-a)2 FULL NAME Charles F. WindhamSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Retired</u>
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6 DATE OF BIRTH <u>December 7, 1861</u> (Month) (Day) (Year)
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7 AGE <u>69 yrs. 7 mos. 4 ds.</u>	If LESS than 1 day... hrs. or min.?
--------------------------------------	-------------------------------------

8 OCCUPATION (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed or (employer)	<u>Retired</u>
--	----------------

9 BIRTHPLACE (State or country)	<u>Maryland</u>
------------------------------------	-----------------

10 NAME OF FATHER <u>William C. Windham</u>	PARENTS
11 BIRTHPLACE OF FATHER (State or country)	
12 MAIDEN NAME OF MOTHER <u>Mary Catherine Rabbitt</u>	
13 BIRTHPLACE OF MOTHER (State or Country)	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Monett Windham(Address) Laytonsville15 Filed Aug 7, 1930 C. S. Barnsley
Registrar

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8/6/30, 1920
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from 8/4/30, 1920 to 8/6/30, 1920that I last saw him alive on 8/6/30, 1920and that death occurred on the date stated above, at 3 p. m.

The CAUSE OF DEATH * was as follows:

Lobar pneumonia(Duration) 3 yrs. 3 mos. 3 ds.Contributory
SecondaryCardiac Dilatation(Duration) 6 yrs. 6 mos. 6 ds.(Signed) Chas. L. Smith M. D.8/7/30 1920 (Address) Laytonsville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 4 mos. 4 ds. In the State LifeWhere was disease contracted, if not at place of death? Home in LaytonsvilleFormer or usual residence Laytonsville, Md

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockville Union Church August 8, 1930

20 UNDERTAKER

ADDRESS

Ray W. Barber Laytonsvilleper issued

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Senile," etc.), "Droopy," "Debility" ("Congenital," "Coma," "Convulsions," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Harford

Village or City Wheaton

2 FULL NAME Richard Clayton Stuard

01837 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 214

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Sept 8 1877
(Month) (Day) (Year)

7 AGE 52 yrs. 5 mos. 11 ds. IF LESS than 1 day hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work Caretaker
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) MD

10 NAME OF FATHER Jos Aguililla Wackerham

11 BIRTHPLACE OF FATHER (State or country) MD

12 M maiden NAME OF MOTHER Anna Wackerham

13 BIRTHPLACE OF MOTHER (State or Country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. J. G. Wackerham

(Address) Wheaton, Harford Co., Md.

15 Filed Feb 23 1920

Registrar W. R. Humphrey

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Feb 22 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 17 1920 to Feb 22 1920

that I last saw him alive on Feb 22 1920

and that death occurred on the date stated above, at 3:00 p.m.

The CAUSE OF DEATH * was as follows:

Pneumonia

Contributory Pneumonia (Duration 6 yrs. 6 mos. 6 ds.)

Secondary Pneumonia (Duration 6 yrs. 6 mos. 6 ds.)

(Address) Wheaton, Harford Co., Md.

*State the cause of death, or, in case of violent causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 6 yrs. 6 mos. 6 ds. In the State 6 yrs. 6 mos. 6 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Paul's Church, Wheaton, Harford Co., Md.

DATE OF BURIAL Feb 23 1920

20 UNDERTAKER W. R. Humphrey

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Forman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MAR 5 1930
BUREAU V. S.

Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montgomery

03133

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 2223Village or City Takoma Park, No. Md. Washington Sanitarium + Hospital

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mr. Edward C. Wittstatt

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>American White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
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6 DATE OF BIRTH

March 10, 1880
(Month) (Day) (Year)

7 AGE

50 yrs. 0 mos. 17 ds. or LESS than 1 day hrs. min.

8 OCCUPATION

(a) Trade, profession or particular kind of work Proprietor
(b) General nature of industry, business, or establishment in which employed or (employer) Car Shop

9 BIRTHPLACE
(State or country)Washington, DC

10 NAME OF FATHER

Peter Wittstatt11 BIRTHPLACE OF FATHER
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Barbara Geurhardt13 BIRTHPLACE OF MOTHER
(State or Country)Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington Sanitarium + Hosp. Records(Address) Takoma Park, Md.

15

Filed March 27, 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

March 27, 1930March (Month) 27 (Day) 1930 (Year)17 I HEREBY CERTIFY, That I attended the deceased from February 20, 1930 to March 27, 1930.that I last saw him alive on March 27, 1930.and that death occurred on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH * was as follows:

Tuberculosis Myelitis involving last Dorsal and first lumbar Vertebrae.(Duration) 2 yrs. 6 mos. ds.Contributory
SecondaryTuberculosis involving apex of Right Lung (Duration) several yrs. mos. ds.(Signed) W. J. Truman M. D.March 27, 1930 (Address) Washington Sanitarium

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 1 yrs. 1 mos. 5 ds. In the State 1 yrs. 1 mos. 5 ds.Where was disease contracted, Washington, D.C.if not at place of death 4707 8th St., N.W.Former or usual residence Washington, D.C.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Prospect Hill Cem., Washington, D.C. Mar. 29, 1930

20 UNDERTAKER

Joseph Gaudier's Sons

ADDRESS

1542 R. Ave. N.W. Washington, D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At School, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Insanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

APR 3 1930

BUREAU OF

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County

Village or City

2 FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Single</i>
6 DATE OF BIRTH <i>Jan 24 1913</i> (Month) (Day) (Year)		
7 AGE <i>13 yrs. 8 mos. 25 ds.</i> If LESS than 1 day ____ hrs. or ____ min.?		
8 OCCUPATION (a) Trade, profession or particular kind of work <i>School</i> (b) General nature of industry, business, or establishment in which employed or (employer)		
9 BIRTHPLACE (State or country) <i>Md</i>		
10 NAME OF FATHER <i>Wm Newton Wolfe</i>		
11 BIRTHPLACE OF FATHER (State or country) <i>Md</i>		
12 MAIDEN NAME OF MOTHER <i>Sybilie Mallinix</i>		
13 BIRTHPLACE OF MOTHER (State or Country) <i>Md</i>		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15 Filed *Oct 19 1930* *W. L. Lewis*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 19 1930*
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended the deceased from *Oct 19 1930* to *Oct 19 1930*that I last saw him alive on *Oct 19 1930*and that death occurred on the date stated above, at *130P* m.

The CAUSE OF DEATH was as follows:

*Thrown from a motorcycle
causing a fractured skull
accidental*(Duration) ____ yrs. ____ mos. *10 min*Contributory
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) *W. L. Lewis* M. D.*Oct 19 1930* (Address) *Kearney*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*First Glen**Oct 21 1930*

20 UNDERTAKER

ADDRESS

*Wm E. Humphrey**Rockville*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "For man," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 7 1930
BUREAU V. 8.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

Village or City Bickerton (No. _____)

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Saura & Wolfe

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

wid

6 DATE OF BIRTH

June

1848

(Month)

(Day)

(Year)

7 AGE

82 yrs. 3 mos. ds. or min.?

If LESS than
1 day hrs.
ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

Jesse Hyatt

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary Ball

13 BIRTHPLACE OF MOTHER

(State or country)

Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Norman Wolfe

(Address)

Bickerton

15

Filed

Sept 29 1930 E. W. White

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 28, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

Sept 24, 1930 to Sept 28, 1930

that I last saw him alive on Sept 27, 1930

and that death occurred on the date stated above, at 10:30 m.

The CAUSE OF DEATH * was as follows:

Occlusion of heart

(Duration) yrs. mos. ds.

Contributory
Secondary

Coronary heart disease

(Duration) yrs. mos. ds.

(Signed) E. W. White M. D.

Sept 29, 1930 (Address) Poolsville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Hyattstown

DATE OF BURIAL

Sept 30 1930

20 UNDERTAKER

Burdett Bros

ADDRESS

Hyattstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

OCT 6 1930

BUREAU V. S.

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonitis, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *shop pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia, Puerperal peritonitis, etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by falling train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING

WRITE IN INK, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

Village or City

Cherry Chase

(No.)

4004 Ridge

St.

Ward

Registration Dist. No. 216

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Lewis R. Wolford

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

June 13, 1901

(Month)

(Day)

(Year)

7 AGE

29 yrs. 4 mos. 16 ds.

IF LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

Maryland.

10 NAME OF FATHER

H. C. Wolford

11 BIRTHPLACE OF FATHER

(State or country)

Dist. of Columbia

12 MAIDEN NAME OF MOTHER

J. M. Allison

13 BIRTHPLACE OF MOTHER

(State or Country)

Maryland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. H. C. Wolford

(Address)

4004 Ridge St., Ch. Md.

15

Filed Oct. 30, 1920.

Benj. C. Perry

Registrar

12575

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct. 29, 1920

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended the deceased from Oct. 12, 1920, to Oct. 29, 1920,

that I last saw him alive on Oct. 29, 1920,

and that death occurred on the date stated above, at 10-0 a.m.

The CAUSE OF DEATH * was as follows:

Typhoid fever

Contributory
Secondary

(Duration) yrs. mos. 17 ds.

Acute Peritonitis

(Duration) mos. 1 ds.

(Signed)

Benj. C. Perry M. D.
Oct. 30, 1920, (Address) Bethesda Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds.

In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockville Md

Oct. 30, 1920

20 UNDERTAKER

ADDRESS

W. R. Pumphrey

Rockville Md

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto, Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

if this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed

RECEIVED

NOV 6 1930

DEPT. OF HEALTH

WRITE ALWAYS, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N.B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

03134

(128)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Takoma Park (No. Washington St. Sanitarium & Hospital Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Sarah Adeline Wallaender

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) married

6 DATE OF BIRTH August 31, 1845
(Month) (Day) (Year)

7 AGE 84 yrs. 7 mos. 28 ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work none - now
(b) General nature of industry, business, or establishment in which employed or (employer) housewife until 2 years ago

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER William Powell

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucinda Larkton

13 BIRTHPLACE OF MOTHER (State or Country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hospital Records
(Address)

15 Filed March 28 1930 H. E. Rogers
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar 28, 1930
March (Month) 28 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 8, 1930 to Mar 28, 1930

that I last saw her alive on Mar 27, 1930

and that death occurred on the date stated above, at 5.55 a.m.
The CAUSE OF DEATH * was as follows:

Acute Bronchopneumonia
nephritis
(Duration) ____ yrs. ____ mos. 14 ds.

Contributory Myocardial
Secondary Arteriosclerosis
(Duration) ____ yrs. ____ mos. 7 ds.

(Signed) W. J. G. H. M. D.
3-27 1930 (Address) Takoma Park Md

*State the Cause Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. 1 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Washington D.C.

19 PLACE OF BURIAL OR REMOVAL Washington D.C. DATE OF BURIAL Mar 28, 1930

20 UNDERTAKER John P. Wright Co ADDRESS Washington D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Turner (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Irritation," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
APR 3 1920
BUREAU

WRITE CLEARLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Mont

Village or City Rockville (No. _____)

2 FULL NAME Oscar Wood Jr.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 23, 1930
(Month) (Day) (Year)

7 AGE 7 yrs. 21 mos. 21 ds. or LESS than 1 day hrs. min.?

OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry business, or establishment in which employed or (employer) None

8 BIRTHPLACE (State or country) Ind

10 NAME OF FATHER Oscar Wood Sr.

11 BIRTHPLACE OF FATHER (State or country) Ind

12 MAIDEN NAME OF MOTHER Elizabeth Duffin

13 BIRTHPLACE OF MOTHER (State or Country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Oscar Wood

(Address) Rockville Maryland

15 Filed 7/16 1930 Mr. H. T. Platt Registrar

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

6 DATE OF DEATH Nov 14, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 11-12 1930 to 11/14 1930, that I last saw him alive on 11/14 1930, and that death occurred on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH * was as follows:

Broncho-pneumonia

(Duration) 4 yrs. 4 mos. 4 ds.

Contributory Secondary None

(Signed) C. E. Hewes M. D.
(Address) Rockville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 4 yrs. 4 mos. 4 ds. In the State 4 yrs. 4 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Rockville Md 11-16 1930

20 UNDERTAKER

ADDRESS

Geo H. Snowden Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

DEC 2 1930
BUREAU V. S.

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Village or City

(No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than
1 day.... hrs.
..... yrs. mos. ds. or min. ?

8 OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

08516

74-a

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended the deceased from

that I last saw him alive on

and that death occurred on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH was as follows:

Contributory

Secondary

(Signed)

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death

..... yrs. mos. da.

to the State

..... yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationery freeman*, etc. But in many cases, especially in industrial employment, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Turn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

"unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonium*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. *Artery's* quality all diseases resulting from childbirth or miscarriage as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolving wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

SEP 8 1930

RUPP

MARGIN RESERVED FOR BINDER
WRITE IN PENCIL, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

09406

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Takoma Park (No. Washington San. + Hosp. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Baby Robert Yetuvesonne

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH May 26, 1930
(Month) (Day) (Year)

7 AGE X yrs. 2 mos. 18 ds. or min.? (If LESS than 1 day, hrs.)

8 OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER J. Carroll Yetuvesonne

11 BIRTHPLACE OF FATHER (State or country) Nebraska

12 MAIDEN NAME OF MOTHER Pansy Bessoe

13 BIRTHPLACE OF MOTHER (State or Country) Mississippi

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington Sanitarium records
(Address) Takoma Park, Md.

15 Filed Aug 13 1930 H. E. Rogers.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 13, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from July 30 1930 to August 13, 1930, that I last saw him alive on August 13, 1930, and that death occurred on the date stated above, at 4 45 p.m. The CAUSE OF DEATH * was as follows:

Acute lymphatic leukemia

(Duration) since birth yrs. mos. ds.

Contributory
Secondary

(Signed) J. E. Glavin M. D. (Address) 8/13/30 192

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 201 Spruce Street, T. P.

19 PLACE OF BURIAL OR REMOVAL Bedar Hill Cemetery DATE OF BURIAL Aug 14, 1930

20 UNDERTAKER The Saffin Co ADDRESS 2901 14th St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Cool mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cool, Housemaid, etc.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Droopy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicaemia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbonic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the date is essential and must be obtained before the certificate is permanently filed.

MARGIN RESERVED FOR BINDING
WRITE MAIN, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

Village or City Beltsville (No. 10561)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 213

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Arthur E. York

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Sept 3 1880
(Month) (Day) (Year)

7 AGE 50 If LESS than 1 day hrs. 14 yrs. 14 mos. 14 ds. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work For Clerk
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) D.C.

10 NAME OF FATHER Isaac York

11 BIRTHPLACE OF FATHER (State or country) N.C.

12 MAIDEN NAME OF MOTHER Charline Martin

13 BIRTHPLACE OF MOTHER (State or Country) N.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Minie York

(Address) Kensington

15 Filed 9-19 1920 Mrs. W. T. Pratt
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 17, 1920
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Sept 17, 1920 to Sept 17, 1920

that I last saw her alive on Sept 16, 1920

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH was as follows: White Mince poisoning

Contributory (Duration) yrs. mos. ds.
Secondary Valerian

(Signed) Sept 17, 1920 (Address) Kensington

*State the Disease Causing Death or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Harmony

DATE OF BURIAL Sept 17, 1920

20 UNDERTAKER Sea & Mawden

ADDRESS Beltsville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed, or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum, etc., Carcinoma, Sarcoma, etc., of* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asphemia," "Anaemia" (merely symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmation," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

OCT 4 1930

BUREAU

WRITE ALWAY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. ACE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

08517

(159-C)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

214

Village or City

Silver Spring Linwood

(No.)

St.

Ward)

If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Young, Cleo Regina

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

May 10, 1930
(Month) (Day) (Year)

7 AGE

1 yrs. *27* mos. *27* ds. or min. ?

If LESS than 1 day....hrs.

8 OCCUPATION

(a) Trade, profession or particular kind of work

None

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Linwood, Montgomery Co

10 NAME OF FATHER

Proctor, Bernard

11 BIRTHPLACE OF FATHER

(State or country)

Hyattsville Md.

12 MAIDEN NAME OF MOTHER

Doris Young

13 BIRTHPLACE OF MOTHER

(State or country)

Linwood Silver Spring Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Doris Young

(Address)

Silver Spring

15

Filed

*July 7, 1930**J. B. Redding*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 7, 1930
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from

July 6, 1930, to July 7, 1930.
that I last saw him alive on *July 7, 1930.*and that death occurred on the date stated above, at *3:45* p.m.

The CAUSE OF DEATH was as follows:

Dysentery, catarrhal enteritis

(Duration) yrs. mos. ds.

Contributory Secondary

Malformation macrocephalic

(Duration) yrs. mos. ds.

(Signed) *W. Mitchell* M. D.*July 7, 1930* (Address) *Silver Spring Md.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.... yrs. mos. da.

In the State, yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Linwood Md**July 7, 1930*

20 UNDERTAKER

David Young

ADDRESS

Silver Spring Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonium*, etc.; *Carcinoma*, *Sarcoma*, etc.. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Gengential," "Senile," etc.), "Dropsy," "Extremities," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from *emphysema* or *miscarriage* as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state *MANS* or *INSTRUMENT* and qualify as *accidental*, *surgical*, or *homicidal*, or, as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Retained wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (The commendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is filled over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

N.B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Montg.

05727

(185)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216Village or City Chevy Chase (No. 102)East Kirk St. St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Frances Young

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Fem.</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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6 DATE OF BIRTH

July 17th, 1838

(Month) (Day) (Year)

7 AGE

91 yrs. 9 mos. 21 ds. or min.?If LESS than
1 day ____ hrs.
1 day ____ ds. or min.?

8 OCCUPATION

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed or (employer) _____

None.

9 BIRTHPLACE

(State or country)

Penn.

10 NAME OF FATHER

James H. Young

11 BIRTHPLACE OF FATHER

(State or country)

Penn.

12 MAIDEN NAME OF MOTHER

Agnes Spence

13 BIRTHPLACE OF MOTHER

(State or country)

Ireland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion Young(Address) 5904 Con. Ave., Chevy Chase Md.

15

Filed 5-8-1930 Thomas X. Conrad Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 8th, 1930

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from
May 7th 1930 to May 8, 1930that I last saw her alive on May 8th 1930and that death occurred on the date stated above, at 172000

The CAUSE OF DEATH * was as follows:

ShockxPulmonary Oedema.(Duration) yrs. mos. shxContributory
SecondaryFall resulting in a fracture of Left Humerus (S.N.)(Duration) yrs. mos. 1 ds.(Signed) Thomas X. Conrad

M. D.

5-8-1930 (Address) Chevy Chase, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death 22 yrs. ____ mos. ____ ds.In the State 22 yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence above

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Washington, D.C.5/9/1930

20 UNDERTAKER

Jos. Sawlers Sons, Wash, D.C.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public
Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school, or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia,"

unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Mosles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (mere symptom-atic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Heart failure," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is asked over thoroughly and all questions answered in detail, it will prevent further correspondence. The data is essential and must be obtained before the certificate is permanently filed.